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healthcare financial management association

ISSUE ANALYSIS

MEDICARE INCENTIVE PAYMENTS FOR MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS: Accounting and Reporting Developments

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Introduction

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that "meaningfully use" certified electronic health record (EHR) technology.¹ These provisions of ARRA, together with certain of its other provisions, are referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act's overall public policy goal is "to promote the adoption and meaningful use of interoperable health information technology and qualified electronic health records (EHRs)."² The government's ultimate goal is to promote more effective (quality) and efficient healthcare delivery through the use of technology—reducing the total cost of health care for all Americans and using the savings to expand access to the healthcare system.

ARRA set aside \$19 billion for making incentive payments to hospitals and physicians that implement and meaningfully use EHR technology by 2014. Incentive payments will be paid out over four years on a transitional schedule. To qualify for incentives under the HITECH Act, hospitals and physicians must meet EHR "meaningful use" criteria. The Centers for Medicare & Medicaid Services (CMS) chose to take a phased approach to defining meaningful use (through three stages), using criteria that become more stringent over time.

Generally, it appears that short-term acute care IPPS hospitals³ receiving Medicare incentive payments have accounted for them using either a *contingency model* or an *IAS 20 grant accounting model*. Although the Securities and Exchange Commission (SEC) had not issued any formal views on EHR income recognition at the time this paper was published, preliminary indications are that SEC registrant hospitals are applying a contingency model. Other hospitals—i.e., those that are privately-held, not-for-profit, or governmental—appear to be choosing between the two models as a matter of accounting policy. If an SEC registrant chooses to apply any model other than a gain contingency model, consultation with the SEC staff is strongly recommended.

The remainder of this position paper discusses accounting for the incentive payments under the two accounting models. Because the SEC has not yet issued any views on the specific requirements associated with the contingency model, the primary emphasis of this paper is on the grant accounting model.

About P&P Board Issue Analyses

The Healthcare Financial Management Association through its Principles and Practices (P&P) Board publishes issue analyses to provide short-term practical assistance on emerging issues in healthcare financial management. To expedite information to the industry, issues analyses are not sent out for public comment. Therefore, they are factual, but not authoritative. The purpose of this issue analysis is to provide some clarity to the healthcare industry on certain accounting and reporting issues resulting from incentive payments under the Medicare program for the meaningful use of electronic health record (EHR) technology. Consultation on these matters with independent auditors is highly recommended. Also, Security and Exchange Commission registrants that are contemplating use of a method other than the contingency model are encouraged to consider pre-clearing their views with the SEC staff.

1. See the July 28, 2010, *Federal Register* (starting on page 44314) for the final rule issued by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, that implements the applicable provisions of ARRA.

2. *Federal Register*, p. 44316.

3. This is referring to "subsection (d) hospitals" in section 1886(d)(1)(B) of the Social Security Act that are paid under the hospital inpatient prospective payment system (IPPS) and are located in one of the 50 states or the District of Columbia.

Note: Because this is an area where accounting practices are just starting to emerge, entities are strongly encouraged to discuss accounting for the incentive payments with their independent auditors as soon as possible. In addition, SEC registrants that are contemplating use of a method other than the contingency model are encouraged to consider pre-clearing their views with the SEC staff.

Scope

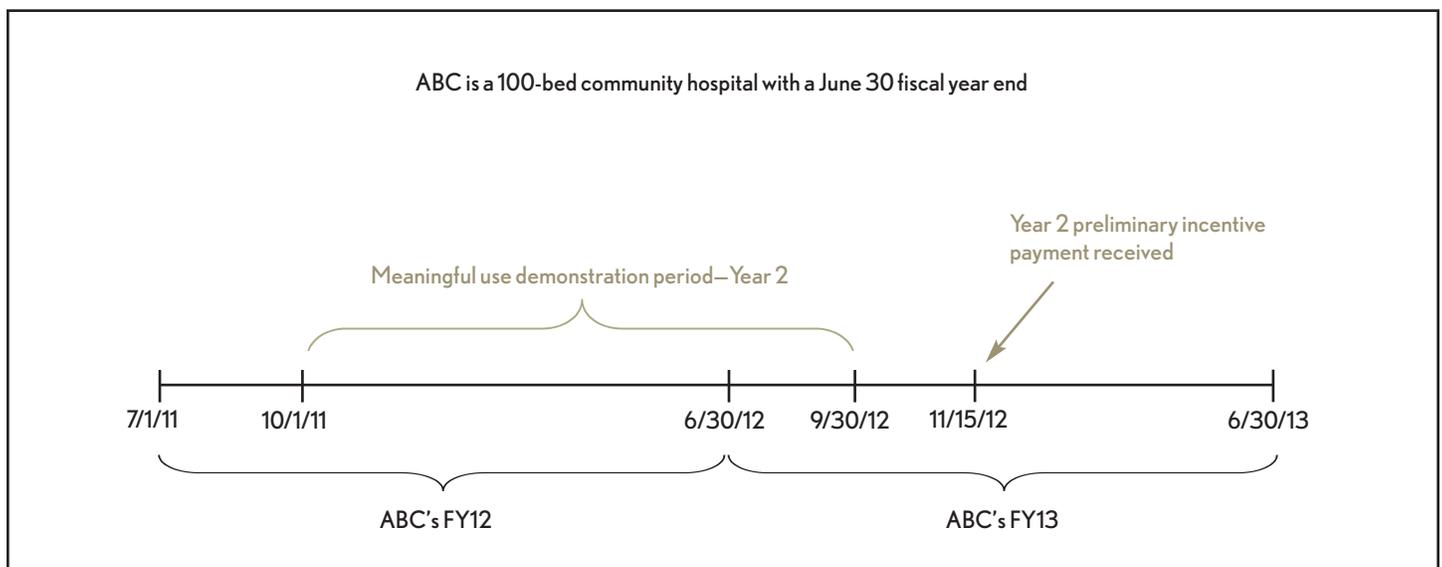
This paper focuses on accounting for the Medicare EHR incentive payments to acute-care inpatient hospitals that are paid under the IPPS. The provisions of the incentive program are applied differently to critical access hospitals (CAHs) and eligible professionals (EPs); however, read in conjunction with the rules applicable to those types of providers, the concepts discussed in this position paper may be useful in determining the appropriate accounting in those situations as well. The concepts discussed in this position paper may also be helpful in determining the appropriate accounting for incentive payments received under state Medicaid programs, which are similar in some ways to the Medicare incentive program.

Overview of Accounting Models

Contingency Model

A key consideration in applying the contingency model is appropriately identifying the contingencies that must be satisfied prior to recognizing the revenue. When EHR incentive payments are viewed within the context of a contingency model, one contingency involves the fact that receipt of an incentive payment occurs only if the hospital is successful in complying with the meaningful use criteria during the entire EHR reporting period (90 consecutive days in the first payment year and 365 consecutive days during each of the second through fourth payment years). The contingency model would not permit income from incentive payments to be recognized until the hospital has actually complied with the meaningful use criteria for the full EHR reporting period in a given year. For example, if in the first payment year the hospital successfully complied with the criteria during days 1 through 89 but failed to comply on day 90, the entire incentive payment for that year would be forfeited. However, if compliance was maintained for the entire 90 day period, income could be recognized on the 90th day if the discharge condition noted below is also met as of that day. It would not be appropriate under a contingency model to consider the probability of complying with the requirements when considering when to recognize income from the incentive program.

FIGURE 1—Juxtaposition of EHR reporting period and ABC Hospital's fiscal year

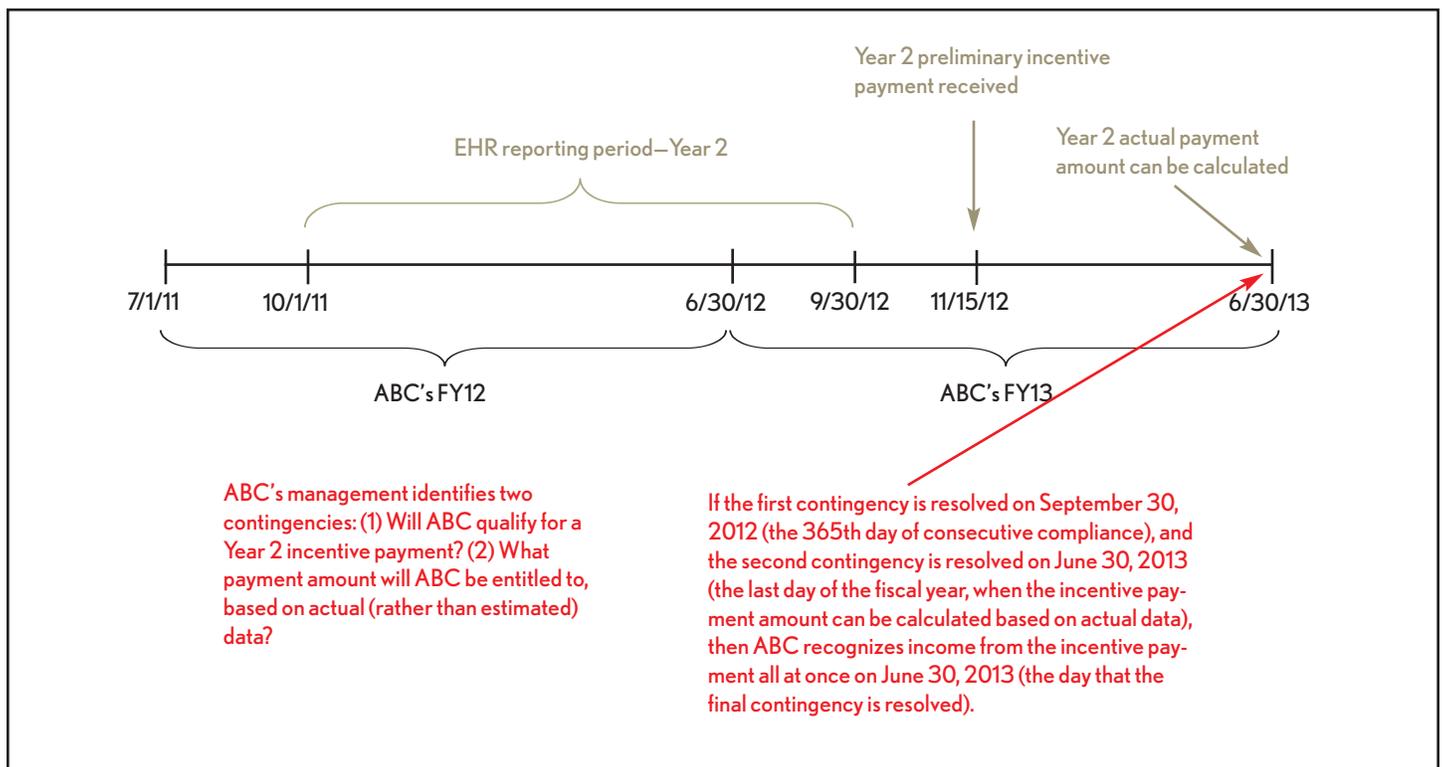


Another potential contingency relates to the discharges upon which the final incentive payment is based. As discussed in Appendix B of this paper, Medicare's incentive payments are based on a formula which utilizes discharges occurring during a hospital's cost report year⁴ that begins in the EHR reporting period (see Figure 1). The EHR reporting period is based on the federal fiscal year, which runs from October 1 through September 30. Therefore, unless an entity's fiscal year coincides with the federal fiscal year, a portion of the discharges used in the payment calculation will occur after the EHR reporting period ends. Because the actual numbers of Medicare discharges and total discharges will typically not be known until the hospital's fiscal year has ended, under a contingent gain model, these amounts would likely be considered an uncertainty that must be resolved prior to recognition of income. Similar considerations may apply to the total charges, charity care charges, and patient days used in the final incentive payment calculation. It is therefore expected that hospitals using the contingency model would typically not meet the contingency for discharge and other final payment calculation data until the last day of the cost report year.

Under the contingency model, the income from the incentive payments would be recorded entirely in the period in which the last remaining contingency is resolved (see Figure 2). Thus, the cash received or receivable from an incentive payment would be recognized as income entirely in a single quarter (i.e., the last quarter of the fiscal year end that is used in the incentive payment calculation).

Submission of the cost report and its subsequent desk review or audit by CMS would not likely be viewed as contingent events that must occur prior to the recognition of income.

FIGURE 2—Illustration of application of contingency model—ABC Hospital



4. It is assumed that the hospital's cost report year coincides with its fiscal year.

Healthcare entities applying a contingency model should give careful consideration to all the potential contingencies and contemporaneously support and document how such contingencies were considered and/or resolved. In addition, preparers using the contingency model should monitor additional accounting and reporting developments as they occur.

IAS 20 Grant Accounting Model

U.S. GAAP's guidance on accounting for government grants received by business enterprises is limited. However, International Accounting Standard 20, *Accounting for Government Grants and Disclosures of Government Assistance* (IAS 20), deals directly with this topic. While IAS 20 is not authoritative guidance under U.S. GAAP (for both nongovernmental and governmental entities),⁵ it has been used widely in practice by U.S. companies for situations where a government provides resources to a business entity in return for past or future compliance with specified conditions relating to the operating activities of the entity, including situations where the purpose of the assistance is to encourage the entity to embark on a course of action which it would not normally have taken if the assistance was not provided.⁶ Many hospitals view this guidance as being relevant with respect to EHR incentive payments, since the purpose of the payments is to induce healthcare organizations to accelerate the pace of adopting EHR technology. Specifics associated with applying the IAS 20 grant accounting model are discussed in the next section.

Application of the IAS 20 Grant Accounting Model

This section demonstrates how a hospital would apply the IAS 20 grant accounting model. The following questions are addressed:

- What type of grant does the EHR incentive payment represent?
- At what point should income associated with EHR incentive payments be recognized?
- How can management determine whether there is reasonable assurance that meaningful use has been or will be achieved for a particular period?
- May an entity estimate the income associated with EHR incentive payments?
- In what area of the statement of comprehensive income should an entity report the grant income?
- What disclosures should be made relating to the grants?

See Appendix A for an example of how a hospital would account for incentive payments relating to the second payment year.

What type of grant does the EHR incentive payment represent?

As discussed earlier, the objective of the EHR incentive payments is to advance the government's public policy goal of creating an electronic national health care infrastructure and an EHR for every American. While hospitals are required to utilize EHRs to record and track information, the grant is specifically "to provide incentive payments for the adoption and meaningful use of certified electronic health record technology."⁷ This indicates that the primary condition for entities to receive the grant money is not to be reimbursed for acquiring long-term assets but rather, to be meaningfully using the EHR technology that is acquired.

IAS 20, paragraph 3, defines two types of grants: *grants related to assets* and *grants related to income*. *Grants related to assets* are defined as "government grants whose primary condition is that an entity qualifying for them should purchase, construct or otherwise acquire long-term assets." *Grants related to income* are defined as "government grants other than those related to assets." Incentive payments are not *grants related to assets* because the stipulating conditions relate to meeting defined compliance objectives (meaningful use) rather than to making discrete purchases of long-term assets. As a result, the EHR incentive payments represent a grant related to income.

5. Although GAAP established by the FASB or GASB is the official established U.S. GAAP, when a transaction is not addressed in U.S. GAAP, entities may look to other sources of established accounting principles, such as International Accounting Standards.

6. Paragraph 4.

7. www.cms.gov/apps/media/press/factsheet.asp?Counter=3793&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&choOrder=date

At what point should income associated with EHR incentive payments be recognized?

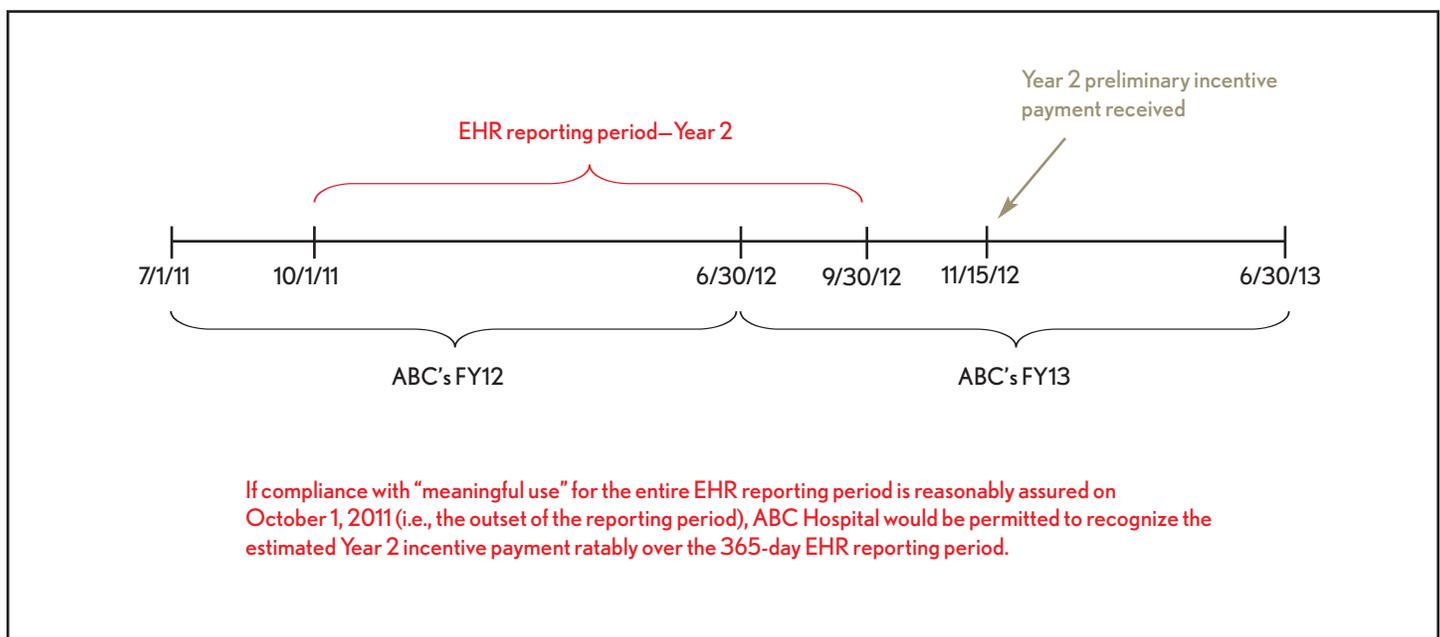
FASB Concepts Statement No. 6, *Elements of Financial Statements* (CON 6), indicates that the goal of accrual accounting is to account for the effects of transactions on an entity in the periods in which they occur to the extent that those financial effects are recognizable and measurable (paragraph 145). CON 6 also indicates that because the existence or amount (or both) of most assets can be probable but not certain, estimates and approximations will often be required (paragraph 46).

IAS 20, paragraph 7, notes that “Government grants... shall not be recognized until there is reasonable assurance⁸ that (a) the entity will comply with the conditions attaching to them; and (b) the grants will be received.” With respect to (b), because the federal government has little credit risk, it is reasonable to consider receipt to be assured once compliance with the meaningful use objectives has been achieved, absent further evidence to the contrary. Additionally, the incentive payment will not be received until the hospital attests that it has fully complied with the conditions attaching to the grant.

With respect to the point at which criterion (a) is met:

- A hospital may not be able to determine with reasonable assurance that it will comply with the conditions associated with the grant (i.e., successfully demonstrate compliance with the minimum number of meaningful use objectives and any other specific grant requirements that are applicable⁹) until after the EHR reporting period has ended, and the income would be recognized all at once at that time. This approach is referred to as “cliff recognition.” If the end of the EHR reporting period (September 30) corresponds with the end of a hospital’s financial reporting period (also September 30) and the hospital verifies that it has met the compliance requirements prior to the issuance of its financial statements (e.g., in November) for that financial reporting period, the hospital would recognize the grant income in that financial reporting period (e.g., the financial reporting period ended September 30).

FIGURE 3—Illustration of application of IAS 20 grant accounting model—ABC Hospital



8. IAS 20 applies the standard of “reasonably assured” as used within International Financial Reporting Standards (IFRS), which may differ from the standard of “reasonably assured” as used within U.S. GAAP. Readers should take that difference into consideration when making this assessment.

9. An example of the latter is the requirement for electronic transmission of quality measures to CMS in the second and subsequent payment years.

- Alternatively, a hospital may be reasonably assured at the outset of the EHR reporting period that it will successfully demonstrate compliance with the minimum number of meaningful use objectives (and any other specific grant requirements that are applicable). Unless facts and circumstances indicate otherwise, there is a rebuttable presumption that because meaningful use technology must be used each day during the compliance period, the grant income would be recognized ratably over the passage of time once the "reasonable assurance" income recognition threshold of IAS 20 is met. In this case, the hospital would meet criterion (a) at the start of the EHR reporting period and thus, may recognize the grant income ratably over the entire EHR reporting period (either 90 or 365 days, as appropriate). This approach is referred to as "ratable recognition" (see Figure 3). Note that management's ability to make the assertion that compliance for the full period is "reasonably assured" at a point prior to the completion of the full EHR reporting period depends, in part, on the extent to which the applicable compliance requirements for the EHR reporting period are objective and on the ability of the hospital's systems to capture the necessary data on an interim basis.
- If compliance with the minimum number of the meaningful use objectives for the entire EHR reporting period (and any other specific grant requirements that are applicable) is not reasonably assured at the outset of the EHR reporting period but instead, is attained at some interim point during the period, then a favorable cumulative catch-up adjustment would be reported at that point to recognize the income earned through that date. The cumulative catch-up adjustment would be necessary to recognize income for the period of time that the hospital complied with the meaningful use criteria prior to management concluding they were reasonably assured of such compliance. The remaining income would be recognized ratably over the remainder of the compliance period.

For example, if management becomes reasonably assured of compliance as of January 1 of an EHR reporting period, then a cumulative catch-up adjustment would be recorded at December 31 to report the ratable portion of the grant income earned during the period October 1 to December 31. The remaining portion of grant income would be recognized ratably over the remaining nine months of the EHR reporting period.

In the event that it is determined that a previously recognized incentive payment is likely to be recouped, a provision for repayment should be made in the financial statements and accounted for as a change in accounting estimate.¹⁰ Similarly, if management is reasonably assured at the outset of the EHR reporting period that the hospital will meet all of the meaningful use objectives for the entire EHR reporting period, but at some point during the reporting period determines that the reasonably assured assertion can no longer be supported, previously recognized grant income should be reversed and accounted for as a change in accounting estimate. Management should evaluate and confirm its reasonable assurance assertion throughout the EHR reporting period.

How can management determine whether there is reasonable assurance that meaningful use has been or will be achieved for a particular period?

"Reasonable assurance" is a matter of judgment that will depend on an individual hospital's particular facts and circumstances. It is important that management can adequately support, through appropriate documentation, the point at which it obtained reasonable assurance that the hospital had met or will meet the applicable EHR meaningful use requirements. As this is a matter of judgment unique to each hospital, there are no "bright line" criteria that can be applied.

In evaluating whether achieving meaningful use for a particular period is reasonably assured, management (and auditors) would likely consider factors such as the following:

- **Has the hospital been operating an EHR system for years, or is it just now beginning to implement an EHR system?** The longer a hospital's system has been in place, the greater the likelihood that problems that could impact the hospital's ability to achieve the requirements will have been identified and resolved.

10. IAS 20, paragraph 32.

- **How long has the hospital been working on meeting the meaningful use criteria?** Some hospitals began running meaningful use compliance reports shortly after issuance of the final rule and using that information to evaluate and further refine their ability to comply with the requirements. A hospital with a demonstrated record of achieving compliance will likely be in a better position to assert “reasonable assurance” than a hospital in the early stages of evaluating its ability to comply.
- **How far along is the hospital with implementing computerized physician order entry (CPOE)?** Because implementing CPOE involves changing physician behavior, many hospitals have identified it as one of the most difficult meaningful use requirements to meet. A hospital that has already successfully implemented CPOE may be in a better position to assert “reasonable assurance” than one that is in the early stages of conducting training programs and modifying its workflow processes.
- **How reliable are the processes and controls around data entry, and how much assurance does the hospital have that they are working correctly?** Implementing new policies and procedures is of minimal value in demonstrating meaningful use unless functioning controls are in place to ensure the requirements are being complied with (for example, controls that provide assurance that orders initiated through a CPOE are entered by an authorized physician or clinician, rather than a nurse or clerk).
- **In using its EHR technology, is the hospital doing the bare minimum required to qualify for meaningful use, or is it going above and beyond?** During Stage 1 of the EHR incentive program there are 24 meaningful use objectives—14 “core set objectives” and 10 “menu set objectives.”¹¹ Hospitals are required to meet all 14 of the core objectives and an additional five objectives chosen from the “menu set”¹² in order to earn a Stage 1 incentive payment. If a hospital unexpectedly falls short on one of the menu set objectives during an EHR reporting period, or if upon audit a fiscal intermediary has a different interpretation of a “gray area” in the regulations involving one of the menu set objectives, a hospital that focused on achieving compliance at levels that consistently exceed minimum requirements may be in a better position to assert “reasonable assurance,” because they have a margin for error or differences in interpretation.

May an entity estimate the income associated with EHR incentive payments?

Page 44450 of the *Federal Register* states the following related to the incentive payment formula: “Congress deliberately chose to limit incentive payments based on the *statutory formula* [emphasis added]...and further limited the amount of incentive payments available to large hospitals by not increasing incentive payments above 23,000 discharges.”

As the grant amount is determined based on a formula, and as that formula includes inputs that may not be known by the entity at the time of recognition (e.g., total discharges, charity charges), the entity should make estimates of those inputs to determine how much should be recognized in income. Since it is clear that the discharge-based formula is an algorithm for implementing payments rather than tied to the compliance activities themselves, and because most hospitals can reasonably estimate their likely Medicare discharges (as well as the other components of the EHR incentive payment calculation) in advance, grant income associated with the meaningful use of EHRs should be recognized based on a reasonable estimate. The need to make estimates should not delay the recognition of grant income in the period in which the related compliance activities take place (i.e., during the EHR reporting period).

As the estimated discharges begin to be replaced by actual discharge, management will revise its estimates as necessary. Subsequent changes in the estimates should be accounted for in accordance with ASC 250-10, which explains that “Changes in accounting estimates result from new information.”

In what area of the operating statement should an entity report the grant income?

IAS 20, paragraph 27, states that “Grants related to income are sometimes presented as a credit in the statement of comprehensive income, either separately or under a general heading such as ‘Other income:’ alternatively, they are deducted in

11. See the *Federal Register*, starting on p. 44370, for a listing of the meaningful use objectives and associated measures.

12. *Federal Register*, p. 44436.

reporting the related expense.” It would not be appropriate to report grant income from the EHR incentive payments as an offset of expense, as the payments are not earned as a result of reimbursing specific expenses incurred in specific periods. Instead, the grant should be displayed as income, either presented separately or included in a caption such as “other income,” depending on the hospital’s facts and circumstances.

In addition to IAS 20’s general requirements described above, hospitals that receive incentive payments need to consider additional financial reporting requirements within U.S. GAAP that differ based on whether the hospital is a privately-held investor-owned entity, a not-for-profit entity, or a governmental entity. (Note: SEC-registered hospitals are excluded from this discussion, because they do not apply the grant model.)

Nongovernmental hospitals

FASB Concepts Statement 6, *Elements of Financial Statements*, provides a useful conceptual framework for preparers of financial statements to distinguish among elements of financial statements for purposes of display. CON 6, paragraph 78, defines revenues as “inflows or other enhancements of assets of an entity or settlements of its liabilities (or a combination of both) from delivering or producing goods, rendering services, or other activities that constitute the entity’s ongoing major or central operations.” This guidance, which directs entities to consider the nature of transactions in light of their relationship to the entity’s ongoing, major, or central activities, is conceptual rather than prescriptive.

It should be noted that neither the ASC requirements pertaining to preparation of a statement of comprehensive income nor those pertaining to a not-for-profit hospital statement of operations require hospitals to segregate activities into operating and nonoperating categories. However, if the hospital’s practice is to segregate activities in that manner, it must consider whether to classify grant payments as operating or nonoperating.

The AICPA’s industry audit and accounting guide for healthcare organizations is a key reference source used in the preparation of financial statements. Prior to 1990, healthcare organizations were required by the initial version of the *Guide*¹³ to report three categories of revenue: *patient service revenue*, *other operating revenue*, and *nonoperating revenue*. The *other operating revenue* classification was to be used for “revenue from nonpatient care services to patients, and sales and activities to persons other than patients”; it explicitly included revenue from grants, gifts, or subsidies that were received in support of research, education, or other programs. The *nonoperating revenue* classification generally was used to report unrestricted contributions and investment income. In light of issuance of CON 6, a new edition of the *Guide* issued in 1990¹⁴ deleted the requirement to classify certain types of income within certain captions, but continued to illustrate use of *patient service revenue*, *other revenue*, and *nonoperating gains (losses)* classifications in the illustrative financial statements.

Thus, a long-standing industry practice exists of reporting income that is not derived from providing health care services but that is related to other ongoing or central activities in an other revenue classification above income from operations. Use of an other revenue classification continued to be illustrated in the illustrative financial statements for both for-profit and not-for-profit entities in the 1996 version of the *Guide*.¹⁵ Further, ASC 954-605-05-4 acknowledges the long-standing practice by stating that “*other revenue*, gains, or losses are derived from services other than providing health care services or coverage to patients, residents, or enrollees.” ASC 954-605-05-4 goes on to describe these types of items, such as tuition for nursing schools, rental of facility space, and dividends and interest from investment activity. While not critical to the delivery of patient services, such items could nonetheless be related to the hospital’s ongoing and central activities. It also is common for entities in the healthcare industry to include grant income in this classification.

13. *Hospital Audit Guide*, issued by the AICPA in 1972.

14. *Audits of Providers of Health Care Services*.

15. In October 2011, the 1996 version of the *Guide* was replaced with a new version which omitted the illustrative financial statements. The illustrative financial statements can still be found in the AICPA’s publication, *Checklists and Illustrative Financial Statements for Health Care Entities*.

Because EHR technology is not critical to the delivery of patient services, and the related incentive payments are similar to revenues derived from sources other than providing healthcare services as described above, some nongovernmental hospitals may conclude that it is appropriate to present this income above operating income as “other revenue” (i.e., above other income, but presented separately from patient service revenue to distinguish the grant income from other inflows). Other hospitals may conclude that the incentive payments are peripheral and incidental to the hospital’s ongoing and central activities and thus, present the grant income in a nonoperating classification. Hospitals should determine the presentation that best fits their facts and circumstances within the parameters of existing GAAP.

More important than presenting grant income as a revenue or contra-expense item, or as operating or nonoperating, is providing financial statement users with adequate information to assess the nature of the inflow and its effects on the hospital. Such payments are clearly distinct from patient revenues, and should be presented separately from patient revenues for that reason. Whatever geographical location is selected for this separate presentation should be consistently applied throughout the periods that the hospital receives incentive payments and clearly disclosed in the notes to the financial statements.

Governmental hospitals

As discussed in paragraph 15.19 of the *Guide*, the GASB’s standards for presentation of the statement of revenue, expenses, and changes in net assets require organizations to distinguish between operating and nonoperating activities, and to provide an intermediate subtotal for operating income or loss. The GASB standards also require that a policy be established for defining operating revenue and expenses that is appropriate to the nature of the activities being reported; however, the determination of which revenue and expenses should be classified as *operating* should consider how the underlying transactions would be classified in the statement of cash flows.¹⁶ Cash flows that do not meet the requirements for reporting in the investing, capital and related financing, or noncapital financing activities categories of the cash flow statement are, by default, reported within the “operating” category. Revenue associated with operating cash inflows would likely be regarded as operating revenue.¹⁷

GASB literature uses the term “exchange-like” to refer to transactions in which the values exchanged may not be quite equal or in which the direct benefit may not be exclusively for the parties to the transaction, but which nonetheless have exchange characteristics which are strong enough to justify treating the transaction as an exchange for accounting purposes.¹⁸ The Task Force believes it is reasonable for GASB hospitals to conclude that the incentive payments are exchange or exchange-like transactions (rather than nonexchange transactions such as subsidies); therefore, the incentive payments would be reported as operating revenue (but presented separately from patient service revenue).

What disclosures should be made relating to the grants?

IAS 20 requires the following disclosures:¹⁹

- a) The accounting policy adopted for government grants, including the methods of presentation adopted in the financial statements;
- b) The nature and extent of government grants recognized in the financial statements and an indication of other forms of government assistance from which the entity has directly benefited; and
- c) Unfulfilled conditions and other contingencies attaching to government assistance that has been recognized.

To meet the IAS 20 objectives, it would be appropriate for all hospitals (nongovernmental and governmental) to disclose the following information:

16. GASB Statement No. 34, paragraph 102.

17. GASB’s nonauthoritative *Comprehensive Implementation Guide*, item 7.73.1.

18. GASB Statement No. 33, paragraph 1, fn 1.

19. Paragraph 39.

- a) The recognition policy applied to grant income, including the method of recognition of grant income relating to the incentive payments (cliff or ratable recognition) and the location of the grant income in the statement of comprehensive income, if not apparent from details disclosed on the face of the statement.
- b) A general description of the incentive program, including the nature of the incentive payments, how the incentive payments are calculated, and the attestation process.
- c) A discussion of the fact that the amount of grant income recognized is based on management's best estimate and that amounts recognized are subject to change, with such changes impacting operations in the period in which they occur. The hospital typically would disclose the nature of and amount of material changes in accounting estimate relating to grant income. In addition, the hospital would disclose the fact that its attestation is subject to audit by the federal government or its designee.

The extent of disclosure would be dictated by the materiality of the incentive payments to an individual hospital (or health system).

Appendix A

Grant Accounting Model Example

The following example demonstrates accounting for grant income recognition for a Year 2 incentive payment based on facts and circumstances noted in Appendix B under “Calculation and Nature of Incentive Payments” and the following additional assumptions:

- This is the second payment year (or EHR reporting period) of the EHR incentive program, which is the federal fiscal year ended September 30, 2012.
- The Hospital has a June 30 fiscal and cost reporting year end.
- The Hospital’s fiscal year ending within the EHR reporting period is June 30, 2012.
- The Hospital has met the Stage 1 meaningful use criteria in the first EHR incentive payment year (the federal fiscal year ended September 30, 2011).
- The Hospital is reasonably assured that it will comply with the meaningful use criteria for the entire EHR reporting period.
- The Hospital’s original estimate of its Year 2 EHR incentive payment determined on October 1, 2011 is \$618,000.
- The Hospital revised its estimate of its Year 2 EHR incentive payment as of June 30, 2012 based on analysis of year end discharge, charity care, and other input data. The analysis resulted in a revised Year 2 EHR incentive payment estimate of \$650,000.
- The Hospital received a preliminary Year 2 EHR incentive payment of \$620,000 in November 2012.
- The Hospital received a final Year 2 incentive payment of \$655,000 during its fiscal year ended June 30, 2015.
- To the extent account balances are discussed, additional balances resulting from other payment years are ignored.
- The Hospital prepares interim financial statements on a quarterly basis.

The Hospital intends to apply for its Year 2 EHR incentive payment. The hospital demonstrated meaningful use in Year 1, and attested to the 90-day compliance period on June 15, 2011. As the Hospital has continued to use EHR technology in a meaningful way, management has concluded there is reasonable assurance that the Hospital will successfully demonstrate meaningful use and earn a Year 2 EHR incentive payment as well. The Hospital is required to comply with meaningful use criteria for the entire EHR reporting period (i.e., continuous 365-day period).

Management is able to estimate the incentive payment that it ultimately expects to receive based on estimated discharges, charity care, and other input data. The Hospital’s discharges, charity care, and other input data remain relatively consistent over time. If services provided or other factors changed significantly, management would make appropriate adjustments to the estimated incentive payment.

Because management is reasonably assured that it will comply with the conditions of the grant for the EHR reporting period and can reasonably estimate the amount it will receive, the Hospital will recognize the grant income ratably over the EHR reporting period, which begins on October 1, 2011. October 1, 2011 is the start of the second fiscal quarter of the Hospital’s 2012 fiscal year. The Hospital records the following entry for the month ending October 31, 2011:

Due from Medicare	\$51,500 (\$618,000 / 12 months)
EHR Grant Income	\$51,500

Similar entries will be made during the month-end closing processes for November through June 2012.

During the fiscal year 2012 year-end closing process, the Hospital revised its estimate of the Year 2 EHR incentive payment based on analysis of year-end discharge, charity care, and other input data. The analysis resulted in a revised Year 2 EHR

incentive payment estimate of \$650,000. The Hospital records the following cumulative catch-up entry in its fourth fiscal quarter to account for this change in estimate.

Due from Medicare	\$ 24,000 ($[\$650,000 - \$618,000] \times 9/12$)
EHR Grant Income	\$24,000

At the end of its fiscal year (June 30 2012), the Hospital's general ledger will reflect a receivable from the Medicare program of \$487,500 ($\$650,000 / 12 \times 9$) and a corresponding amount of grant income related to the estimated Year 2 incentive payment.

On October 5, 2012, the Hospital submits its Year 2 compliance attestation to CMS and receives a preliminary Year 2 EHR incentive payment of \$620,000 in November 2012 based on the data from the most recently filed cost report (cost report period ended June 30, 2011). Management's estimate of the expected final payment remains the \$650,000 estimate noted above. The Hospital records the following entry in the second fiscal quarter of fiscal year 2013 related to receipt of the EHR incentive payment:

Cash	\$620,000
Due from Medicare	\$620,000

At this point, the Hospital has an estimated receivable of \$30,000 due from the Medicare program relating to the Year 2 EHR incentive payment.

In August 2013, the Hospital files the cost report for its fiscal year ended June 30, 2013 and revises its estimated Year 2 EHR incentive payment to \$660,000 based on settlement information included in the filed cost report (i.e., the cost report period beginning during the second payment year). The Hospital records the following entry in its first fiscal quarter of 2014 to record the revised estimated EHR incentive payment to be received from CMS:

Due from Medicare	\$10,000 ($\$660,000 - \$650,000$)
EHR Grant Income	\$10,000

The \$10,000 difference is accounted for as a change in accounting estimate in its interim financial statements (first quarter of fiscal 2014) and disclosed, if material.

During fiscal 2015, the fiscal intermediary completes its audit of the Hospital's fiscal 2013 Medicare cost report. As noted in Appendix B, CMS utilizes discharge and other data from the audited 2013 Medicare cost report to calculate the amount of the final incentive payment actually earned for the second payment year. As a result of the audit, CMS determines a final EHR incentive payment of \$655,000 was earned by the Hospital. The Hospital records the following entry in fiscal 2015, to record the effects of the settlement of the 2013 audited cost report related to the Year 2 EHR incentive payment:

EHR Grant Income	\$5,000 ($\$660,000 - \$655,000$)
Due from Medicare	\$5,000

The \$5,000 adjustment to grant income is accounted for as a change in accounting estimate as described in IAS 20 in the appropriate quarter of the Hospital's statements and disclosed, if material.

In summary, the total EHR incentive payment recognized in the Hospital's fiscal year ended June 30, 2012 for Year 2 incentive payments is as follows:

Hospital's original estimate of Year 2 EHR incentive payments determined at July 1, 2011 (\$51,500 × 9)	\$463,500
Change in accounting estimate for Year 2 EHR incentive payments determined at June 30, 2012	24,000
Total recognized for the year ended June 30, 2012	\$487,500

Subsequent to fiscal year 2012, the Hospital recognized an additional \$167,500 of the Year 2 EHR incentive payment due to the amount prorated into fiscal 2013 and the changes in estimate relating to prior years.

Year 1 Considerations

The Year 1 EHR reporting period only requires a continuous 90 day compliance period within the federal fiscal year. If, based on its specific facts and circumstances, the Hospital is reasonably assured at the start of or during the Year 1 EHR reporting period that it will successfully demonstrate meaningful use and earn a Year 1 EHR incentive payment, it would recognize grant income ratably starting at the point it became reasonably assured. If management was not reasonably assured that the Hospital met the 90 day compliance requirement until the end of the 90 day compliance period (possibly due to the Hospital attempting to achieve meaningful use for the first time), the Hospital would use the cliff recognition approach discussed in this position paper and record the entire estimated EHR incentive payment as income at the end of the 90 day compliance period.

Appendix B

Background on the Medicare EHR Incentive Payment Program

This Appendix provides additional detailed information on the EHR incentive payment program.

The American Recovery and Reinvestment Act of 2009

Overview

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish one-time incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified EHR technology, and for certain Medicare Advantage organizations whose affiliated professionals and hospitals meaningfully use EHR technology.²⁰ These provisions of ARRA, together with certain of its other provisions, are referred to as the Health Information Technology for Clinical and Economic Health (HITECH) Act. Eligible acute care inpatient hospitals are defined as “subsection (d) hospitals” in section 1886(d)(1)(B) of the Social Security Act, and are hospitals that are paid under the hospital inpatient prospective payment system (IPPS) and are located in one of the 50 states or the District of Columbia.

ARRA, signed into law by President Obama on February 17, 2009, sets aside \$19 billion for incentive payments to hospitals and physicians that implement and use EHR technology by 2014. Incentive payments will be paid out over four years on a transitional schedule. To qualify for incentives under the HITECH Act, hospitals and physicians must meet designated EHR meaningful use criteria. The Centers for Medicare & Medicaid Services (CMS) chose to take a phased approach to defining meaningful use (through three stages), using criteria that become more stringent over time. In Stage 1, applicable to the 2011 and 2012 payment years, hospitals have to meet 14 “core,” or mandatory, objectives and an additional five objectives chosen from a “menu set” of 10 options, of which at least one must address public health objectives. While the Stage 1 criteria are well defined, Stage 2 and 3 requirements are still being developed. It is anticipated that, as the technology infrastructure improves, CMS will significantly increase requirements in the next two stages—with a focus on safety, efficiency, and continuous quality improvement at the point of care.

Public Policy Goals

The government’s stated public policy goal with respect to the HITECH Act is “to promote the adoption and meaningful use of interoperable health information technology (HIT) and qualified electronic health records (EHRs).”²¹ The goal of the HITECH Act as it relates to providing incentives for hospitals to become meaningful users of certified EHR technology is to:

- Improve quality, safety, efficiency, and reduce health disparities.
- Engage patients and families in their health care.
- Improve coordination of care.
- Improve public and population health.
- Maintain privacy and security.

Per CMS’s website:

Through the Medicare and Medicaid EHR incentive programs, CMS hopes to expand the meaningful use of certified EHR technology. Certified EHR technology used in a meaningful way is one piece of a broader Health Information Technology infrastructure needed to reform the health care system and improve health care quality, efficiency, and patient safety.... CMS’ goal is for the definition of meaningful use to be consistent with applicable provisions of Medicare and Medicaid law

20. See the July 28, 2010, *Federal Register* (starting on page 44314) for the final rule issued by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, that implements the applicable provisions of ARRA.

21. *Federal Register*, p. 44316.

while continually advancing the contributions certified EHR technology can make to improving health care quality, efficiency, and patient safety. To accomplish this, CMS' final rule would phase in more robust criteria for demonstrating meaningful use in three stages.

The government's ultimate goal is to promote more effective (quality) and efficient healthcare delivery through the use of technology—reducing the total cost of health care for all Americans and using the savings to expand access to the healthcare system.

“Meaningful Use” Criteria

For hospitals, the key component of receiving the EHR incentive payments is “demonstrating meaningful use,” which means meeting a series of objectives that make use of an EHR's potential related to the improvement of quality, efficiency, and patient safety. CMS has indicated that demonstrating meaningful use will be phased in during the next few years in three stages, with each progressive stage incorporating more stringent measures, as follows:

- Stage 1
 - Electronically capture health information in a coded format.
 - Use certified EHR technology to meet 14 required core objectives. In addition, hospitals are required to meet 5 more objectives selected from a menu set of 10.
- Stage 2
 - Expands on Stage 1 to focus on continuous quality improvement at point of care, greater use of computerized physician order entry (CPOE), and more exchange of information.
- Stage 3
 - Expands on the previous stages to focus on promoting improvements in quality, safety, and efficiency with an emphasis on decision support, patient access to self-management tools, access to comprehensive patient data, and improving population health.

In Stage 1 there are 24 meaningful use objectives—14 “core set objectives” and 10 “menu set objectives.”²² As noted above, hospitals are required to meet all 14 of the core objectives and an additional five objectives chosen from the menu set of 10 objectives.²³ Some examples of the measurements for Stage 1 include: maintain active medication list (80 percent requirement), record and chart changes in vital signs (50 percent of all unique patients age 2 and older admitted to the hospital, record blood pressure and body mass index (BMI), and plot growth chart for children 2 to 20), and record smoking status for patients 13 years or older (50 percent requirement). In order to qualify for the EHR incentive payments, hospitals will be required to operate a certified EHR, ensure its work flow/practice captures the information, and be able to report its achievement of the key metrics as defined by CMS for the applicable stage. The specific meaningful use objectives for Stage 1 have been developed and published by CMS²⁴; the specific objectives for Stages 2 and 3 have not yet been developed. CMS has indicated that it expects to issue the Stage 2 and Stage 3 criteria by the end of federal fiscal years 2011 and 2013, respectively²⁵.

The primary objective of the government is to expand the use of EHR technology by creating a national healthcare infrastructure and EHR for every American in order to achieve societal benefits. CMS explains in Question 6 of its Electronic Health Record In-

22. See the *Federal Register*, starting on page 44370, for a listing of the meaningful use objectives and associated measures.

23. *Federal Register*, p. 44436.

24. *Federal Register*, p. 44370.

25. *Federal Register*, p. 44321.

centive Program FAQs (EHR FAQs) that the three main components of meaningful use are: (1) the use of a certified EHR in a meaningful manner (e.g., e-Prescribing); (2) the use of certified EHR technology for electronic exchange of health information to improve quality of health care; and (3) the use of certified EHR technology to submit quality and other measures.²⁶

The majority of the Stage 1 criteria relate to capturing data currently being captured but in a different way (electronically vs. manually). For example, hospitals currently maintain an up-to-date problem list of current and active diagnoses. In Stage 1, hospitals will have incentives to maintain that information as structured data in an electronic form. As another example, hospitals currently perform drug-drug and drug-allergy interaction checks. To meet the relevant Stage 1 objective, hospitals will be required to simply enable this functionality in their EHR. Still another example relates to capturing demographic data (e.g., preferred language, gender, race, date of birth). Currently, hospitals capture this data in manual charts. In Stage 1, hospitals will be required to capture such data in a structured format for more than 50 percent of all unique patients admitted to the hospital.

Registration and Attestation

In order to receive incentive payments, a hospital which is able to meet the meaningful use criteria must attest²⁷, through a secure mechanism, in a manner specified by CMS, that during the EHR reporting period, the hospital:

- Used certified EHR technology and specify the technology used.
- Satisfied the required meaningful use objectives and associated measures for the applicable stage (Stage 1, 2 or 3).
- Must specify the EHR reporting period and provide the result of each applicable measure for all patients admitted to the inpatient or emergency department of the hospital during the EHR reporting period for which a selected measure is applicable.

For federal fiscal year 2012 and subsequent years (subsequent payment years), the hospital must attest to the foregoing and in addition, will be required to report hospital clinical quality measures selected by CMS electronically to CMS in the manner specified by CMS.²⁸

Hospitals were permitted to begin registering with CMS for the Medicare EHR incentive program on January 3, 2011, and to begin providing attestations for the Medicare program in April 2011. Medicare EHR incentive payments began in May 2011. The last day for hospitals to register and attest to receive an incentive payment for federal fiscal year 2011 (the first payment year) is November 30, 2011. Hospitals can first qualify as meaningful users in federal fiscal year 2013 and still receive the full four years of incentive payments. Qualifying as a meaningful user of EHR technology after federal fiscal year 2013 results in smaller total incentive payments.

According to Question 25 of the EHR FAQs, “hospitals will have to demonstrate meaningful use through CMS’s web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. In the Registration and Attestation System, providers will fill in numerators and denominators for the meaningful use objectives and quality measures, indicate if they qualify for exclusions to specific objectives, and legally attest that they have successfully demonstrated meaningful use. Once providers have completed a successful online submission through the Attestation System, they will qualify for a Medicare EHR incentive payment.”

²⁶. All references to CMS’s Electronic Health Record Incentive Program FAQs are to the version last updated on October 2, 2011, which may be accessed at www.cms.gov/EHRIncentivePrograms/Downloads/FAQsRemediatedandRevised.pdf.

²⁷. *Federal Register*, p. 44571. Also, note that hospitals must keep documentation of meaningful use for six years.

²⁸. However, in the final rule CMS did not specify when or how often hospitals will be required to submit data and provided no other details about the submission process. This requirement to report certain measures electronically starting with the second payment year is contingent upon CMS’s readiness to accept such electronic reporting.

Incentive Payments

Overview of Payment Years and EHR Reporting Periods

A hospital may receive an incentive payment for up to four years, provided it successfully demonstrates meaningful use of certified EHR technology for the EHR reporting period. Hospitals that adopt a certified EHR system and are meaningful users can begin receiving incentive payments in any federal fiscal year (which is referred to as a “payment year”²⁹) from 2011 (that is, October 1, 2010 - September 30, 2011) to 2015; however, the incentive payments will decrease for hospitals that first start receiving payments in federal fiscal year 2014 or 2015.

Meaningful use will be assessed on a year-by-year basis. If a hospital demonstrates meaningful use in one payment year but fails to demonstrate meaningful use of certified EHR technology in a later payment year, it will not qualify for incentive payments for that later payment year. However, upon subsequent successful demonstration as a meaningful EHR user, the hospital may once again be eligible to receive an incentive payment. However, the failure of the hospital to demonstrate meaningful use in a later payment year will affect the total incentive payments the hospital is eligible to receive, as pursuant to the statute, the hospital is treated as skipping a payment year.³⁰ The hospital would be unable to “recapture” any missed year due to failure to meet the meaningful use requirements.

With certain exceptions, the EHR reporting period for hospitals is as follows:³¹

- For the first payment year, any continuous 90-day period within a federal fiscal year.³²
- For the second, third, fourth, fifth and sixth payment year, the federal fiscal year.

In other words, for the first year a hospital demonstrates meaningful use of certified EHR technology, the EHR reporting period equals any 90 continuous days beginning and ending within a federal fiscal year. For every year thereafter, the EHR reporting period is the entire federal fiscal year (i.e., the hospital must demonstrate meaningful use of the EHR technology for the continuous 365-day period beginning October 1 and ending September 30). All hospitals will use the federal fiscal years as their EHR reporting periods, regardless of their individual fiscal year ends.

Calculation and Nature of Incentive Payments

The EHR incentive payment to hospitals for each payment year is calculated as the product of (1) an initial amount; (2) the Medicare share; and (3) a transition factor applicable to that payment year.³³ The mechanics of the calculation may be displayed as follows:

Initial Amount	X	Medicare Share	X	Transition Factor
<ul style="list-style-type: none"> • \$2 million base + • Discharge-related amount: \$200 for discharge 1,150 through 23,000 		<ul style="list-style-type: none"> • Part A IP + Part C IP days³⁴ • Divided by: (Total IP days) X ((Total charges – charity care charges)/Total charges) 		<ul style="list-style-type: none"> • Payment year 1: 100% • Payment year 2: 75% • Payment year 3: 50% • Payment year 4: 25% • Payment year 5: 0%

29. The payment year for hospitals is the federal fiscal year (October 1 to September 30). *Federal Register*, p. 44318.

30. *Federal Register*, p. 44319.

31. *Federal Register*, p. 44566.

32. In other words, for hospitals that want to qualify for incentive payments in the first payment year (federal fiscal year 2011), the hospitals must begin meaningful use of certified EHR technology on or before July 3, 2011 (i.e., 90 days prior to the end of federal fiscal year 2011).

33. *Federal Register*, p. 44450.

34. “Part A” refers to the Medicare IP program and “Part C” refers to the Medicare Advantage (Medicare HMO) program. “IP” refers to inpatients.

The following example illustrates the calculation of the incentive payment for the second payment year.

Hospital-specific data:	
Total hospital discharges	11,750
Total inpatient (IP) days	45,000
Medicare days:	
Part A Medicare days	7,500
Part C Medicare days	300
Total Medicare days	<u>7,800</u>
Charge information:	
Total gross charges	\$150,000,000
Less charity care charges	<u>20,000,000</u>
Total charges, net of charity care	\$130,000,000

$$\begin{aligned}
 & \$2,000,000 + (\$200 \times 10,600 \text{ eligible discharges}) = \$4,120,000 \quad \times \quad \left(\frac{7,800 \text{ Medicare days}}{45,000 \text{ total days}} \times \left(\frac{\$130,000,000}{\$150,000,000} \right) = 20\% \right) \quad \times \quad 75\%
 \end{aligned}$$

$$\$4,120,000 \times 20\% \times 75\% = \$618,000$$

The “discharge-related amount” is defined as “the sum of the amount, estimated based on total hospital discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

- (i) for the first through the 1,149th discharge, \$0.
- (ii) for the 1,150th through the 23,000th discharge, \$200.
- (iii) for any discharge greater than the 23,000th, \$0.”³⁵

It should be noted that based on the definition of the discharge-related amount, CMS is not reimbursing the hospital for providing services to specific patients. Discharges less than 1,150 and greater than 23,000 are excluded from the calculation. Additionally, as part of the EHR incentive payments, CMS did not develop an approach that paid hospitals for each Medicare discharge (consistent with how acute-care hospitals are reimbursed under the IPPS). Under IPPS, hospitals receive a payment for providing services to Medicare patients on a per-claim (per-discharge) basis. Since the incentive payment calculation is

35. Federal Register, p. 44450.

not designed to pay hospitals for providing services to specific patients, it appears that it was developed simply as a mechanism to allocate the \$19 billion set aside for EHR incentive payments by ARRA to eligible hospitals and other providers that achieve meaningful use of certified EHR technology.

Also, it should be noted that the incentive payments are not intended to reimburse hospitals for the cost to acquire and implement EHR technology. Instead, according to Question 13 of the EHR FAQs, the “EHR Incentive Programs provide incentive payments for the meaningful use of certified EHR technology...The incentives are not a reimbursement of costs, and maximum payments have been set.” Also, many hospitals have already implemented EHR technology and for those that have not, the incentive payments are unlikely to cover the cost of the acquisition and implementation of the technology.

Per Section 1886(n)(2) of the Act,³⁶ CMS will employ discharge and other data from the hospital’s most recently filed 12-month cost report as the basis for determining the hospital’s *preliminary* EHR incentive payment once the hospital has qualified (attested) as a meaningful user. CMS provides the following example:

FY2011 begins October 1, 2010 and ends on September 30, 2011. For an eligible hospital with a cost reporting period on the October-to-September cycle, we would employ the relevant data from the hospital’s most recently submitted cost reporting period in order to determine the incentive payment for the hospital during FY 2011. If the hospital qualifies for incentive payments on January 1, 2011, this would probably be the cost report for the period running from October 1, 2008 through September 30, 2009. However, we would also employ the October 1, 2009 through September 30, 2010 cost report, if that cost report is submitted before the point when preliminary incentive payments can be calculated.*

**NOTE: The above example from the Federal Register is for illustrative purposes only. Eligible hospitals were not permitted to begin attesting to meaningful use of EHR until April 2011.*

CMS has indicated that EHR incentive payments will be made approximately four to six weeks after a hospital successfully attests it has demonstrated meaningful use of certified EHR technology. Payments to hospitals will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels that the hospital’s claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.³⁷

Per Section 1886(n)(2) of the Act,³⁸ CMS will determine the final EHR incentive payment at the time of settling the 12-month cost report for the hospital’s fiscal year that begins after the beginning of the payment year, and to be settled on the basis of the hospital’s discharge and other data in that cost reporting period. CMS provides the following example:

FY2011 begins October 1, 2010 and ends on September 30, 2011. For an eligible hospital with a cost reporting period running from July 1 through June 30, we would employ the relevant data from the hospital’s cost reporting period ending June 30, 2009 in order to determine the preliminary incentive payment for the hospital during FY 2011 (or June 30, 2010, if that cost report was filed prior to the calculation). However, final payments would be based on hospital discharge data from the cost reporting beginning on July 1, 2011 and ending June 30, 2012, and determined at the time of settlement for that cost reporting period.

As noted earlier, the EHR reporting period (i.e., compliance period) is the federal fiscal year (other than the first payment year, when it is 90 consecutive days within the federal fiscal year). Therefore, in the example above, the discharges during the reporting period (90 consecutive days within the federal fiscal year ending September 30, 2011) will not be the same dis-

36. Federal Register, p. 44451.

37. From CMS’s response to submitted questions: http://questions.cms.hhs.gov/app/answers/detail/a_id/10160

38. Federal Register, pp. 44451 - 44452.

charges used to calculate the hospital's incentive payment. The final incentive payments will be calculated using discharges and other data from the hospital's cost report for its fiscal year ending June 30, 2012.

Lower Future Reimbursement Increases for Failure to Meet Meaningful Use

The Medicare program pays hospitals a predetermined rate (the IPPS rate) for inpatient services furnished to Medicare beneficiaries. Under the IPPS, a base payment rate for each discharge is multiplied by a measure (called a "diagnosis-related group") which reflects the nature/acuity of that condition. Each year, Medicare announces whether it plans to make an across-the-board inflation adjustment to base payment rates and if so, by how much. This inflation adjustment (the hospital market basket increase, our MBU) is based on projections of growth in the prices of goods and services purchased by hospitals.

Hospitals that have not become meaningful users of certified EHR technology by federal fiscal year 2015 will receive a reduced MBU (i.e., lower increase than otherwise would have been received) to the IPPS standardized payment amount. The reduction will apply to three-quarters of the percentage increase otherwise applicable. The reduction to three-quarters of the applicable update for a hospital that is not a meaningful user by federal fiscal year 2015 is 33 1/3 percent, 66 2/3 percent, and 100 percent for federal fiscal years 2015, 2016, and 2017 and each subsequent federal fiscal year, respectively.³⁹ In other words, hospitals that are not meaningful users by federal fiscal year 2015 will see the following reductions of their MBU (i.e., lower increase compared to other hospitals that are meaningful users):

Federal Fiscal Year	Reduction in MBU
2015	1/4
2016	1/2
2017 and subsequent years	3/4

For example, if the MBU for federal fiscal year 2015 year was 2.8 percent (i.e., the amount each hospital's IPPS standardized payment amount will increase over the federal fiscal year 2014 amount) and a hospital did not achieve meaningful use of EHR technology by federal fiscal year 2015, the hospital would receive an increase of 2.1 percent. The significance of this smaller increase will depend on each hospital's specific facts and circumstance (i.e., the hospital's total IPPS payments from the Medicare program).

39. *Federal Register*, p. 44460.

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