

Critical Access Hospitals' Receipt of Medicare and Medicaid Electronic Health Record Incentive Payments

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Purpose

This policy brief has three purposes: 1) to describe current Critical Access Hospital (CAH) participation in the Medicare and Medicaid EHR incentive programs; 2) to compare CAH participation by state; and 3) to evaluate the differences in CAH participation by hospital characteristics.

Introduction

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 authorized the establishment of Medicare and Medicaid incentive payment programs for eligible hospitals, including CAHs, which achieve "meaningful use" (MU) of Electronic Health Records (EHRs). Hospitals may qualify for incentive payments from Medicare, Medicaid, or both. For the purposes of qualifying for these incentives, CMS has defined three stages of MU of certified EHRs: stage 1 focuses on electronically storing health information and reporting quality measures and public health information, stage 2 focuses on health information exchange, and Stage 3 is likely to focus on promoting improvements in quality, safety, and efficiency as well as decision support for national high priority conditions. Detailed information may be found at the CMS website: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.

The Medicare EHR Incentive Program is administered by the Centers for Medicare and Medicaid Services (CMS). CAHs must demonstrate MU for a 90-day period in their first year of participation. In subsequent years, they must demonstrate it for a full fiscal year, with the exception of 2014, when all providers are only required to demonstrate MU for a 3-month reporting period.¹ CAHs could begin receiving EHR incentive payments anytime from FY 2011 to FY 2015. Under the existing timeline as of November 2014, Medicare incentive payments decrease for CAHs that start receiving payments in 2014 and later, and CAHs will be subject to a reduction in their Medicare reimbursement beginning in FY 2015 if they do not successfully demonstrate MU.²

Medicaid EHR Incentive Programs are administered by State Medicaid agencies; eligible hospitals must have at least 10% Medicaid patient

Key Findings

- As of September 2014, 1,194 Critical Access Hospitals (CAHs) (89%) had received any Medicare and/or Medicaid Electronic Health Record (EHR) incentive payments.
- 150 CAHs received Medicaid incentives for adoption, implementation, or upgrade (AIU) only, while 1,031 and 696 CAHs received incentives for meaningful use (MU) from Medicare and Medicaid, respectively. A total of 683 CAHs (51%) received both Medicare and Medicaid MU incentives.
- By state, the percentage of CAHs receiving any EHR incentive payment ranged from 44% in Hawaii to 100% of CAHs in eight states (Arkansas, Florida, Maine, Massachusetts, New Mexico, Pennsylvania, Vermont, and Virginia). The percentage of CAHs that received MU incentive payments ranged from 44% in Hawaii to 100% in Vermont and Virginia.
- CAHs that received any EHR incentives, including AIU and/or MU, were significantly more likely to have 25 beds (the maximum number of beds for a CAH), and to have more Medicare and Medicaid inpatient discharges, but less likely to be private for-profit, than those that did not receive an incentive.
- Compared to CAHs that only received AIU incentives, CAHs that received MU incentives were significantly more likely to have 25 beds and to be accredited by the Joint Commission or the American Osteopathic Association, but less likely to be system members.

volume.² Medicaid programs, unlike Medicare, offer incentive payments for hospitals to adopt, implement, or upgrade EHRs in the first year without requirements to demonstrate MU of certified EHR technology until the subsequent year.¹ Unlike the Medicare Incentive Program, the Medicaid Incentive Programs do not have reimbursement reductions for not demonstrating meaningful use.

Data and Methods

This policy brief presents the results of an analysis of CAH Stage 1 EHR incentive payments, including the type and timing of incentives by state and by key hospital characteristics. Three data sources were used for this analysis: 1) a data file of Medicare and Medicaid EHR incentive payments from 2011 through September 2014 for all CAHs, provided to the federal Office of Rural Health Policy by CMS; 2) the Flex Monitoring Team (FMT) CAH database; and 3) the FY 2011 American Hospital Association Annual Survey. These data sources were linked using the CAHs' Medicare provider number.

The variables in the CMS data file included the type of incentive program (Medicaid or Medicare), year when a hospital applied for incentive payments, number of payments a hospital received, incentive payment criteria (AIU, and MU attestation), and hospital location (state

and ZIP code). Variables from the FMT CAH database included the date of CAH certification and number of beds. AHA Survey variables included system membership, accreditation by the Joint Commission or the American Osteopathic Association, ownership type (private non-profit, public/government, or for-profit), and number of Medicare and Medicaid inpatient discharges.

To compare CAHs that received incentive payments and those that did not, as well as CAHs that received payments for AIU only and those that received them for MU, Chi-square statistics and two-sample t-tests were used for categorical and numeric responses, respectively.

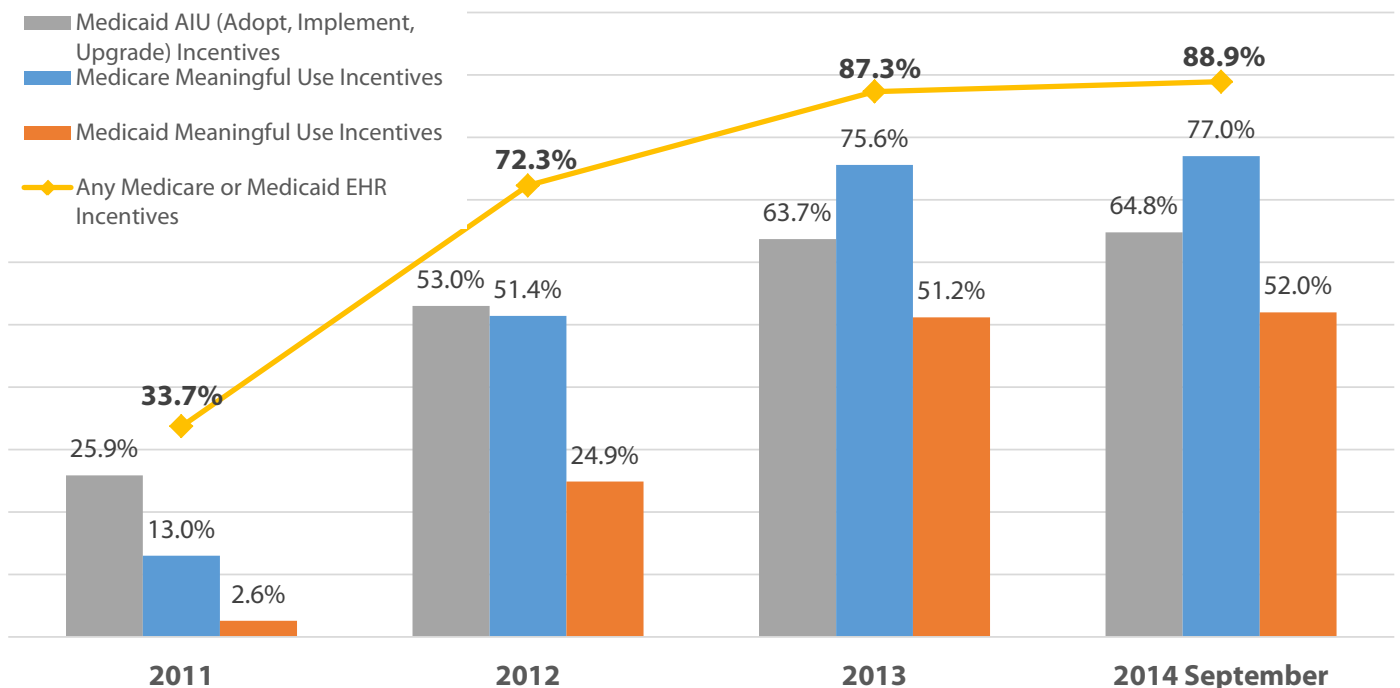
Results

EHR Incentive Payments for CAHs

The percentage of CAHs that received any EHR incentive payments increased from 33.7% in December 2011 to 88.9% in September 2014 (Figure 1).

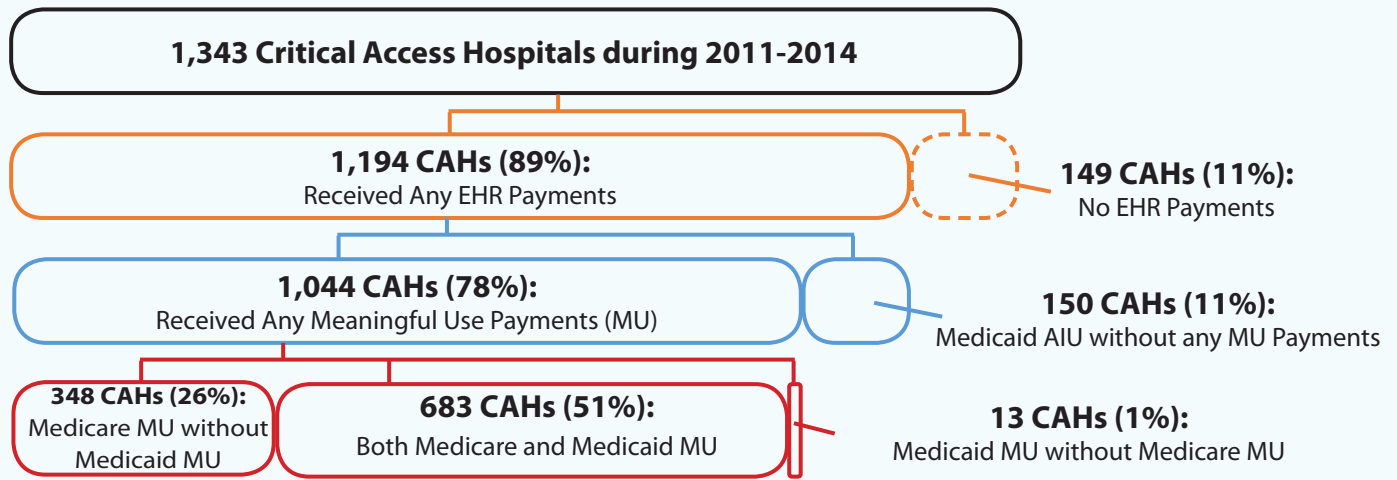
As of September 2014, about 65% of CAHs had received AIU incentives from their state Medicaid program. Seventy-seven percent had received Medicare MU incentive payments, while 52% of CAHs had received Medicaid MU incentives. The majority of CAHs started to demonstrate Medicare MU in 2012, while most CAHs started demonstrating Medicaid MU in 2013.

Figure 1. Initial Receipt of Electronic Health Record Payments by CAHs January 2011 - September 2014



Data Sources: ORHP Medicare & Medicaid EHR incentive payments data, and Flex Monitoring Team CAH Database.

Figure 2. Distribution of CAHs' Receipts for Meaningful Use, September 2014 (N=1,343)



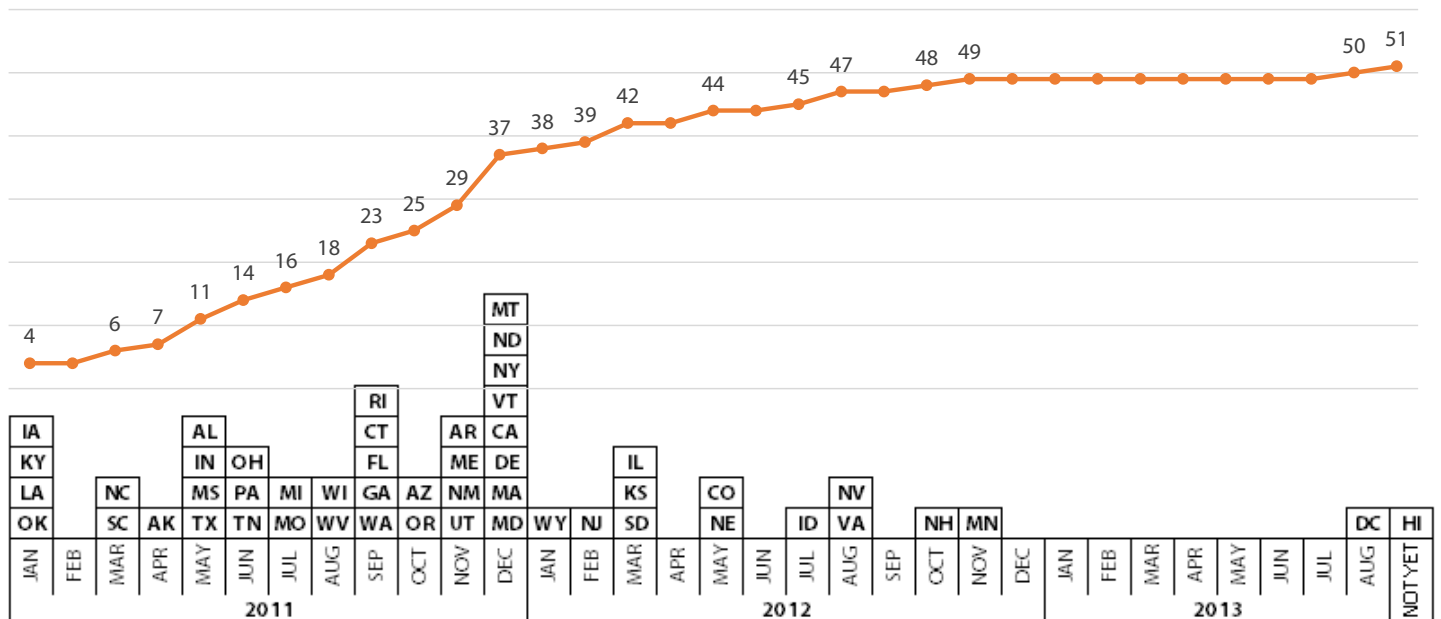
Notes: Percentages represent the share of 1,343 CAHs during 2011-2014.
 MU= meaningful use of EHR; AIU = adopt, implement, upgrade EHR
 Data Sources: ORHP Medicare & Medicaid EHR incentive payments data, and Flex Monitoring Team CAH Database.

Almost 90% of the 1,343 CAHs had received some type of EHR incentive payment under the Medicare and/or Medicaid program as of September 2014 (Figure 2). About 11% of CAHs only received Medicaid payments for AIU. Fifty-one percent of CAHs received both Medicare and Medicaid payments for MU attestation, while 26% received MU attestation incentives only under the Medicare program and less than 1% only under the Medicaid EHR program. Although incentives for AIU are meant to facilitate MU, 150 CAHs that received AIU incentives had not qualified to receive MU incentives by

September 2014. Eighty-six of these 150 CAHs received the AIU incentives prior to December 2012; 51 of them received the incentives in 2013, while 13 received in 2014.

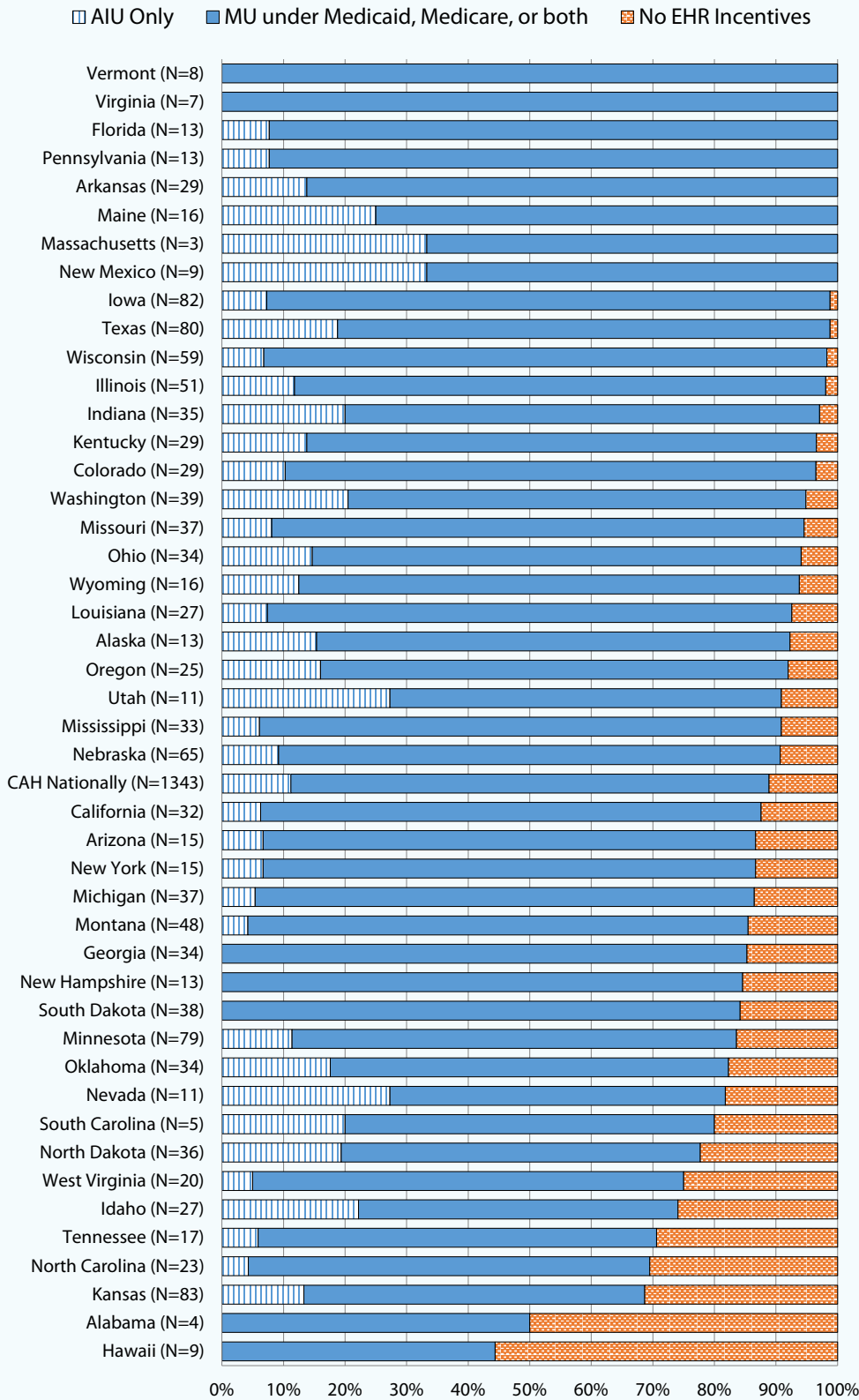
CAH EHR Incentive Payments by State
 Thirty-seven states began disbursing Medicaid EHR incentive payments in 2011; 12 states started in 2012, and Washington DC began in 2013 (Figure 3). Hawaii initiated its program in September 2013, and had not disbursed any payments as of November 2014.

Figure 3. Number of State Medicaid EHR Programs that Initiated Incentive Payments, January 2011-September 2014



Data Source: ORHP Medicare EHR incentive payments data.

Figure 4. Percent of CAHs Receiving Medicare or Medicaid EHR Incentive Payments by State and Type, September 2014



Data Sources: ORHP Medicare & Medicaid EHR incentive payments data, and Flex Monitoring Team CAH Database.

The percentage of CAHs that had not received EHR incentives from either Medicare or Medicaid varies greatly by state, ranging from 0% in eight states to 56% in Hawaii (Figure 4). Compared to the national rate of 11%, the eight states on the top of Figure 4 are significantly ahead and the bottom five states are significantly behind. These differences are largely related to the date when a state initiated its Medicaid EHR incentive program.

Among CAHs that received EHR incentive payments, the percentage of CAHs that only received AIU without MU attestation ranged from 0% in seven states (Vermont, Virginia, Georgia, New Hampshire, South Dakota, Alabama, and Hawaii) to 33% in Massachusetts and New Mexico. Compared to the national rate of 11%, these rates do not show significant differences. However, more than half of the 150 CAHs nationally that only received AIU incentives received those AIU payments in 2011 or 2012, but had still not achieved MU by 2014. These CAHs with only AIU incentives demonstrate a need for further efforts to facilitate MU among CAHs.

Comparison of CAHs Receiving and Not Receiving EHR Incentive Payments
Table 1 (next page) compares CAHs that received different types of EHR incentives and those that did not receive EHR incentives. CAHs that received any incentives were significantly more likely to have 25 beds (the maximum number of beds for a CAH), but less likely to be proprietary. On average, they had significantly more Medicare and Medicaid inpatient discharges ($P < .001$).

Among CAHs receiving incentives, those with AIU only payments were significantly less likely to have 25 beds and to be accredited, but more likely to be system affiliated than those receiving MU incentives. However,

Table 1. Comparison of CAHs with and without EHR Incentives, September 2014

	EHR Incentive Receipt Status			Significance of Differences ^a		
	No EHR Incentives (N=149)	AIU Only (N=150)	Any MU (N=1,044)	No Incentives vs Any Incentives	AIU Only vs. Any MU	No MU vs. Any MU
Bed Size=25	63.1%	66.0%	72.5%	0.035	0.033	0.009
Accreditation	26.8%	25.3%	30.1%	0.567	0.034	0.194
Hospital Ownership						
Government, Non-federal	36.2%	37.3%	42.6%	0.187	0.250	0.070
Not-for-profit	53.0%	54.7%	52.8%	1.000	0.665	0.793
For-profit	10.7%	8.0%	4.6%	0.008	0.106	0.003
System Affiliation	50.3%	54.0%	40.4%	0.065	0.004	P<.001
Medicare Inpatient Discharges (Standard Deviation)	266.5 (214.6)	350 (243.3)	374.8 (264.4)	P<.001	0.280	P<.001
Medicaid Inpatient Discharges (Standard Deviation)	58.8 (80)	91.9 (109.4)	89.9 (109)	P<.001	0.835	0.034

^aSignificance derived by Chi-square tests and t tests for the differences in hospital characteristics between two groups.

Data Sources: ORHP Medicare & Medicaid EHR incentive payments data, Flex Monitoring Team CAH Database, AHA FY11 Annual Survey.

compared to CAHs receiving Medicaid or Medicare MU incentives, CAHs receiving no EHR incentives at all or only AIU incentives, were significantly more likely to be smaller in bed size, to be private for-profit, and to have fewer Medicare and Medicaid inpatient discharges.

Conclusions

It is encouraging that 1,194 (89%) of 1,343 CAHs have received some type of EHR incentive by September 2014, a rate slightly higher than the 87% among all eligible hospitals nationally.³ However, the fact that 150 CAHs had only received AIU payments and 149 other CAHs had not yet applied or demonstrated MU to receive EHR incentive payments is concerning. Although there is a lag between attesting to MU and receipt of EHR incentives, 86 of the 150 CAHs that only received AIU incentives have received the incentive for almost two years.

CAHs that have not qualified for MU incentives may find it difficult to catch up with other hospitals that are moving on to Stage 2 requirements. Progressing to Stage 2 is much more challenging than Stage 1 for CAHs, especially smaller ones who lack the resources of large infrastructure and may not be prioritized by EHR vendors in upgrading to information exchange and

interoperability. Under the CMS final rule released in August 2014, the extension of Stage 2 through 2016 provides CAHs with additional time to receive full EHR incentives.⁴

Monitoring CAH progress in achieving MU is not the role of the Flex Program and Flex Program funds cannot be used to help CAHs achieve MU; however, Flex Programs can share the information in this policy brief with other state stakeholders to increase awareness of the need to help CAHs achieve MU, since CAHs will be subject to Medicare payment reductions if they do not successfully demonstrate meaningful use by 2015. Particular attention should be focused on smaller CAHs that may be facing greater challenges in achieving MU than their larger counterparts.

Differences across states in the percentages of CAHs receiving incentive payments are of concern. These differences may be attributable, at least in part, to delays in initiating state Medicaid EHR incentive programs in some states, and in disbursing Medicaid EHR incentives to hospitals. Now that all states have established their Medicaid EHR programs, continued analysis of Medicaid EHR incentive data is important to ensure the national goals of the HITECH Act are met. ■

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