A Commentary re Critical Access Hospitals and Health Information Technology Incentives in the Economic Recovery Bill

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Talking Points

- The Economic Recovery Bill stated intent was to incent widespread HIT adoption.
- Medicare currently pays all hospitals what it believes is their share of capital costs.
- The original House Bill had no incentives for CAHs, the original Senate Bill had $1.5 million per eligible CAH; the final Bill may only provide, at best, $480,000 in incentives per eligible CAH.
- The result is that the Congressional Budget Office estimates that only half of CAHs will be "meaningful users" of HIT by 2019.
- As the Economic Recovery Bill is implemented, rural voices must work to minimize the above shortfalls.

Background:

The differences are dramatic between Prospective Payment System Hospital (PPS) and Critical Access Hospital (CAH) Medicare incentives in the American Recovery and Reinvestment Act (ARRA). Most PPS hospitals that become eligible for incentive payments will receive over $4 million in added payments. CAHs that become eligible for incentive payments are estimated to receive, in the best of circumstance, only $480,000 in added payments (this is assuming $1.2 million in undepreciated "Certified EHR" costs to apply to the bonus structure). See page 3 for an estimate of the value of the incentive payments.

The original House version of ARRA provided no incentives for CAHs; the Senate version would have provided eligible CAHs $1.5 million in HIT incentives. The Conference Committee created new language not in either the House or Senate versions, with a practical result believed to be much closer to the House bill. In particular, early adopter CAHs will in many to most cases get limited to no incentive payments. As a result, the **Congressional Budget Office estimates that only half of CAHs will be "meaningful users" of HIT by 2019.** Below is the justification used to exclude CAHs from a meaningful HIT incentive on par with PPS hospital incentives, and why the justification is incorrect.

The justification for treating CAHs differently than PPS hospitals (House bill Sec. 4312; Senate bill Sec. 4202; Conference agreement Sec. 4102): "Medicare pays acute care hospitals using a prospectively determined payment for each discharge. These payment rates are increased annually by an update factor that is established. In part, by the projected increase in the hospital market basket (MB) index... **Currently, Medicare's payments to acute care hospitals under the inpatient prospective payment system (IPPS) are not affected by the adoption of EHR technology.** Critical access hospitals (CAHs) receive cost-plus reimbursement under Medicare. Under current law, Medicare reimburses CAHs at 101% of their Medicare costs. These

reimbursements include payments for Medicare's share of CAH expenditures on health IT, plus an additional 1%."

Why the statement used to exclude CAHs from receiving a meaningful incentive is considered by many to be misleading: MedPAC (Medicare Payment Advisory Commission) says "**IPPS pays per-discharge rates that begin with two national base payment rates—covering operating and capital expenses**—which are then adjusted to account for two broad factors that affect hospitals' costs of furnishing care: the patient's condition and related treatment strategy, and market conditions in the facility's location." (i.e. PPS hospitals receive payment for capital expenses, including HIT).

PPS hospitals, as well as CAHs, submit cost report data within 5 months after the end of each fiscal year. All capital costs, including those for HIT, get reported. CMS provides proposed DRG updates (that take into account these reported capital costs) in the spring of each year; the final DRG updates are released in the summer; and the new rates, which include inflation factors, become effective on October 1st. It is true that CMS does not reimburse PPS hospitals for their individual capital costs, but they are reimbursed in the capital portion of their Medicare payment for what CMS estimates to be reasonable capital expenses for an efficiently run hospital.

Understanding why CAHs are reimbursed at actual cost + 1%

CAHs are reimbursed at actual cost plus 1%, rather than cost through DRG payments in order to maintain a safety net of hospital services in rural America. CAHs have a lower volume of inpatients and a proportionately higher cost of operation and capital (since higher volume allows for greater efficiencies). The PPS system was designed for high volume hospitals. After twenty years of failed attempts to adjust it for the conditions faced by rural hospitals, Congress decided to establish a Medicare payment system that took into account the unique challenges faced by rural hospitals.

The justification for CAH cost-based reimbursement can be roughly understood by thinking of it in terms of the REA bringing electricity to rural America, and as the rationale for rural broadband subsidies. There is not enough volume in rural areas to provide these services at the same cost as in urban areas, so we need to treat them differently in order to provide rural residents with basic necessities: electricity, broadband, healthcare. Legislators, especially those with rural constituents, need to understand that CAH cost-based reimbursement was not designed to be higher than PPS reimbursement, but rather equivalent to, given the volume disadvantage in rural communities.

Why Do CAHs Need Incentives Beyond ARRA

- Today, even after years of cost-based reimbursement, CAHs average half the EMR adoption of PPS hospitals.

- The CBO estimates that with the incentive as written still only 50% of CAHs will reach meaningful user designation by 2019

- The impact will be to leave many (half of!) small rural hospitals behind in the next decade's HIT revolution

- This will severely impact the healthcare needs of 15 million Americans that live in small rural communities served by Critical Access Hospitals

Recommended Next Steps

The legislation is now law, and we are, at least for now, left with making the best of a bad situation. Some areas to focus on will include: (1) a short as possible administrative process for establishing "meaningful use," (2) making sure that the "Certified EHR" costs that are eligible for CAH incentives include all aspects of EHR implementation, such as PACS, HIT infrastructure, and hardware, rather than only those that are covered by current certification programs, (3) making sure that grants are available for CAH EHR implementation, and not just for broadband and information exchange, and (4) making sure that individuals who understand rural HIT and reimbursement are in the room when key decisions are made moving forward.

Estimated Additional Value of the Added CAH HIT Incentive

I	Est. Avg. Total "Eligible Certified EHR" Capital Cost Per "Meaningful" CAH	$1,500,000
II	Est. of Un-depreciated Costs When CAH Becomes "Meaningful" (80% of Line I)	$1,200,000
III	Est. Avg. Medicare "Incentive" Share (Inpt & Charity Stimulus Formula)	65%
IV	Est. Accelerated Depreciation II x III	$780,000
V	Incentive Add-On	20%
VI	Value of 20% Add-On (II x V)	$240,000
VII	Est. Accelerated Depreciation + 20% Add-on (Total IV + V)	$1,020,000
VIII	Est. Medicare Share based on Traditional Allocation in Cost Report	45%
IX	Est. Traditional Medicare Cost Reimbursement Would Have Received (II x VIII)	$540,000
X	**Est. Net Incentive Typical Eligible Hospital (VII-IX)**	**$480,000**
XI	Number CAHs	1,300
XII	CBO Estimate of Percentage Who Will Meet Meaninful User Test	50%
XIII	Est. Number Getting Stimulus Incentive (XI x XII)	650
XIV	**Est. Net Additional Payments to CAHs (X x XIII)***	**$312,000,000**

* CBO said to have Scored the CAH Incentive at $600-900 Million

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