



441 G St. N.W.
Washington, DC 20548

October 24, 2013

Congressional Committees

Electronic Health Records: Number and Characteristics of Providers Awarded Medicare Incentive Payments for 2011–2012

Widespread use of health information technology, such as electronic health records (EHR), has the potential to improve the quality of care patients receive and reduce health care costs. However, studies have estimated that as of 2009, 78 percent of office-based physicians and 91 percent of hospitals had not adopted EHRs.¹ The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (Recovery Act), among other things, provided funding for various activities intended to promote the adoption and meaningful use of certified EHR technology.² The largest of these activities, in terms of potential federal expenditures, are the Medicare and Medicaid EHR programs.³ Starting in 2011, these programs have provided incentive payments for certain providers, including both hospitals and health care professionals such as physicians and dentists, that demonstrate meaningful use of certified EHR technology and meet other program requirements established by the Centers for Medicare & Medicaid Services (CMS). Beginning in 2015, the Medicare EHR program is generally required to begin applying a payment adjustment—that is, a payment reduction—for Medicare providers that do not demonstrate meaningful use. The Congressional Budget Office estimated total spending for the Medicare and Medicaid EHR programs to be \$30 billion from 2011 through 2019, of which

¹See C. J. Hsiao, E. Hing, T. C. Socey, and B. Cai, “Electronic Medical Record/Electronic Health Record Systems of Office-Based Physicians: United States, 2009 and Preliminary 2010 State Estimates,” *National Center for Health Statistics Health E-stat* (2010); and A. K. Jha, C. M. DesRoches, P. D. Kralovec, and M. S. Joshi, “A Progress Report on Electronic Health Records In U.S. Hospitals,” *Health Affairs*, no.10 (2010):1951-1957.

²The HITECH Act was enacted as title XIII of division A and title IV of division B of the Recovery Act. Pub. L. No. 111-5, div. A, tit. XIII, 123 Stat. 115, 226-279 and div. B, tit. IV, 123 Stat. 115, 467-496 (2009).

Congress defined “meaningful use” in this context to reflect that the user of health information technology demonstrates to the satisfaction of the Secretary of the Department of Health and Human Services (HHS) that the technology is certified and being used in a meaningful manner, that the technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, and that such information is submitted in a form and manner specified by the Secretary. See Pub. L. No. 111-5, § 4101(a) 123 Stat. 467-472. To be certified, EHR technology must meet certain criteria established by HHS’s Office of the National Coordinator for Health Information Technology that describe minimum related performance standards and implementation specifications.

³See Pub. L. No. 111-5, §§ 4101-4201, 123 Stat. 467-494. Medicare is a federal program financing health care for individuals aged 65 and older, certain disabled individuals, and individuals with end-stage renal disease. In 2012, Medicare covered over 49 million beneficiaries. Medicaid is a federal-state program financing health care for certain low-income individuals. In fiscal year 2011, Medicaid covered about 70 million beneficiaries.

spending for the Medicare EHR program accounts for more than half—\$17.7 billion. This report focuses on the Medicare EHR program.⁴

Provisions in the HITECH Act defined the types of hospitals and professionals that may be eligible to receive Medicare EHR incentive payments. Eligible hospitals include acute care hospitals and critical access hospitals.⁵ Eligible professionals include doctors of medicine, dental medicine or surgery, optometry, osteopathy, and podiatric medicine and chiropractors.⁶ Hospitals can receive Medicare EHR incentive payments for up to 4 years, and professionals can receive such payments for up to 5 years.⁷ To receive incentive payments from the Medicare EHR program, hospitals and professionals must demonstrate meaningful use of certified EHR technology.⁸ The incentive payment amounts are determined as follows:

- For acute care hospitals, the Medicare EHR incentive payment amount for any given year is generally based on the hospital's annual discharges and Medicare share, which is the percentage of the hospital's inpatient bed days that were attributable to Medicare patients. Theoretically, \$6,370,400 is the maximum possible Medicare EHR incentive payment for an acute care hospital for 2012.⁹
- For critical access hospitals, the Medicare EHR incentive payment amount is generally based on the hospital's Medicare share as well as reasonable costs incurred for the purchase of depreciable assets necessary to administer certified EHR technology, such as computers and associated hardware and software. CMS has not established a maximum incentive payment amount for these hospitals.
- For professionals, the amount of Medicare EHR incentive payment in any given year is generally based on the professional's Medicare Part B charges.¹⁰ For most professionals first participating for 2012, the amount of the incentive payment for 2012 could not exceed \$18,000. For most professionals first participating in 2011, the amount of the incentive

⁴The HITECH Act created incentive programs for Medicare fee-for-service, Medicare Advantage, and Medicaid. Under the Medicare Advantage EHR program, Medicare Advantage Organizations—private companies that provide Medicare health insurance coverage to beneficiaries for hospital, physician, and other services—receive incentive payments for certain affiliated professionals and hospitals that meet program requirements. Pub. L. No. 111-5, §§ 4101(c), 4102(c) 123 Stat. 473-476, 484-486. In this report, we refer to the incentive program for Medicare fee-for-service as the Medicare EHR program and, where noted, the incentive program for Medicare Advantage as the Medicare Advantage Organization EHR program.

⁵Acute care hospitals are hospitals described in Section 1886(d) of the Social Security Act, which are paid under the inpatient prospective payment system in the 50 states and the District of Columbia. The hospitals classified as critical access hospitals typically are very small (25 inpatient beds or fewer) and operate in rural areas.

⁶Professionals must practice in one of the 50 states, the District of Columbia, or a U.S. insular area to be eligible for the Medicare EHR program.

⁷In order to maximize the total amount of Medicare EHR incentive payments that could be awarded, acute care hospitals must have first participated in the program by the 2013 program year, and critical access hospitals and professionals must have first participated by the 2012 program year.

⁸For the Medicare EHR program, adopting or purchasing certified EHR technology is not sufficient to receive an incentive payment.

⁹This assumes that all patients served were Medicare patients and that the hospital had at least 23,001 discharges, which is the highest number of discharges CMS includes in the calculation of Medicare EHR incentive payments.

¹⁰Medicare Part B covers hospital outpatient, physician, and other services for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease.

payment for 2012 could not exceed \$12,000. For professionals who predominately furnished services in geographic areas designated as a health professional shortage area, the maximum incentive payment amount was increased by 10 percent, to either \$19,800 or \$13,200.

The HITECH Act requires us to report on, among other things, its effect on the adoption of EHRs by providers.¹¹ In response to this requirement, in April 2012 we reported on CMS's efforts to oversee the Medicare EHR program during its first year as well as challenges encountered by providers and strategies they used to participate in the program.¹² We recommended that CMS take steps to enhance its processes to verify that providers met the requirements to receive incentive payments. On behalf of CMS, the Department of Health and Human Services agreed with most of our recommendations. In July 2012 we reported information on providers that were awarded Medicare EHR incentive payments for 2011, including the number of award recipients and their characteristics.¹³ In December 2012 we reported information on providers that were awarded Medicaid EHR incentive payments for 2011, including the number of award recipients and their characteristics.¹⁴

Concerns have been raised that various factors, such as location in urban or rural areas or the size of hospitals and professional practices, may affect the extent to which different providers will demonstrate the meaningful use of EHR technology in response to the provisions of the HITECH Act. Identifying the number and characteristics of providers that participated during the first and second years of the Medicare EHR program can provide important information on whether certain types of providers were more likely than others to participate. This information could also provide an early indication of the types of providers that may be more likely to receive payment reductions in future years of the program. As discussed with the committees of jurisdiction, in this report we provide this information on providers that were awarded Medicare EHR incentive payments for 2011 and 2012, the first and second years of the program.

To provide information on providers—that is, hospitals and professionals—awarded Medicare EHR incentive payments for 2011 and 2012, we analyzed data related to the 2011 and 2012 program years that CMS collected from January 3, 2011, through July 2, 2013, as well as data from CMS and other government sources on provider characteristics. We used these data to

- determine the number of providers that were awarded a Medicare EHR incentive payment for 2012 and compare that information to the number of providers awarded a Medicare EHR payment for 2011;
- estimate the percentage of eligible providers that were awarded a Medicare EHR incentive payment for 2012 and compare that information to the percentage of providers awarded a Medicare EHR payment for 2011;

¹¹Pub. L. No. 111-5, § 13424(e), 123 Stat. 278-279.

¹²See GAO, *Electronic Health Records: First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements*, [GAO-12-481](#) (Washington, D.C.: Apr. 30, 2012). In our April 2012 report, we analyzed partial-year data that Medicare providers reported to CMS to demonstrate that they meaningfully used their certified EHR technology.

¹³See GAO, *Electronic Health Records: Number and Characteristics of Providers Awarded Medicare Incentive Payments for 2011*, [GAO-12-778R](#) (Washington, D.C.: July 26, 2012).

¹⁴GAO, *Electronic Health Records: Number and Characteristics of Providers Awarded Medicaid Incentive Payments for 2011*, [GAO-13-146R](#) (Washington, D.C.: Dec. 13, 2012).

- determine the amount of Medicare EHR incentive payments awarded to providers for 2012 and compare that information to the amount of Medicare EHR payments awarded for 2011; and
- examine the characteristics of providers that were awarded Medicare EHR incentive payments for 2012 and compare that information to the characteristics of providers awarded Medicare EHR payments for 2011.

To determine the number of providers that were awarded a Medicare EHR incentive payment in each year, we counted the number of providers that had an incentive payment disbursed to them. To estimate the percentage of eligible providers awarded a Medicare EHR incentive payment in each year, we divided the number of providers awarded an incentive payment in the year by the total number of eligible providers in the same year. To determine the total amount of Medicare EHR incentive payments awarded to providers in each year, we summed the Medicare EHR incentive payments awarded to providers in each year. We also examined the distribution of the Medicare incentive payments across providers in each year. Specifically, for hospitals, we determined the minimum, maximum, and median Medicare EHR incentive payment amount in each year. For professionals, we determined the percentage in each year who were awarded an incentive payment of any amount.

To examine the characteristics of providers awarded Medicare EHR incentive payments for 2011 and 2012, we analyzed data from CMS, the Health Resources and Services Administration, and the Office of the National Coordinator for Health Information Technology (ONC). As part of our analysis, we compared the characteristics of providers that were awarded Medicare EHR incentive payments for 2012 to (a) those of providers that were eligible for the Medicare EHR program but were not awarded a payment for 2012 and (b) those of providers that were awarded Medicare EHR payments for 2011. For hospitals, these characteristics included, for example, whether the hospital was classified as an acute care hospital or critical access hospital and whether the hospital was a member of a chain. For professionals, these characteristics included whether the professional had signed an agreement to receive technical assistance from a Regional Extension Center.¹⁵ To ensure the reliability of the various data we analyzed, we interviewed officials from CMS and ONC; reviewed relevant documentation; and conducted electronic testing to identify missing data and obvious errors. On the basis of these activities, we determined that the data we analyzed were sufficiently reliable for our analysis.¹⁶ Enclosure I provides additional information on our scope and methodology.

We conducted this performance audit from April 2013 to October 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹⁵The Regional Extension Center program was established by the HITECH Act and is administered by ONC to help some types of providers, such as those located in rural areas, to participate in CMS's EHR programs.

¹⁶The amount of missing data on provider characteristics was generally low; however, in instances in which data were missing for 6 percent or more of providers, we noted this explicitly in enclosure I and in tables presented in enclosures II and III, as appropriate.

In summary, hospitals and professionals were awarded a total of \$6.3 billion in Medicare EHR incentive payments for 2012, which is more than twice the \$2.3 billion awarded to hospitals and professionals for 2011. For 2011 and 2012, the first 2 years of the Medicare EHR program, hospitals and professionals were awarded a total of \$8.6 billion in Medicare EHR incentive payments. Almost half of eligible hospitals and less than a third of eligible professionals received Medicare EHR incentive payments for 2012.

Hospital incentive payments. For 2012, 2,291 hospitals were awarded a total of \$3.5 billion in Medicare EHR incentive payments.¹⁷ These 2,291 hospitals represent 48 percent of the eligible hospitals and an increase compared to 2011, when 777 hospitals, or 16 percent of those eligible, were awarded payments. (See table 1.) In 33 states, less than half of eligible hospitals received incentive payments for 2012; in 18 states, the percentage that received incentive payments was 50 percent or more.

Table 1: Participation in the Medicare EHR Program by Hospitals

	2011	2012
Number (percentage of eligible)	777 (16)	2,291 (48)
Median payment	\$1.6 million	\$1.4 million
Total payments	\$1.3 billion	\$3.5 billion

Source: GAO analysis of CMS data.

Note: Figures are based on data CMS collected through July 2, 2013, for the 2011 and 2012 program years.

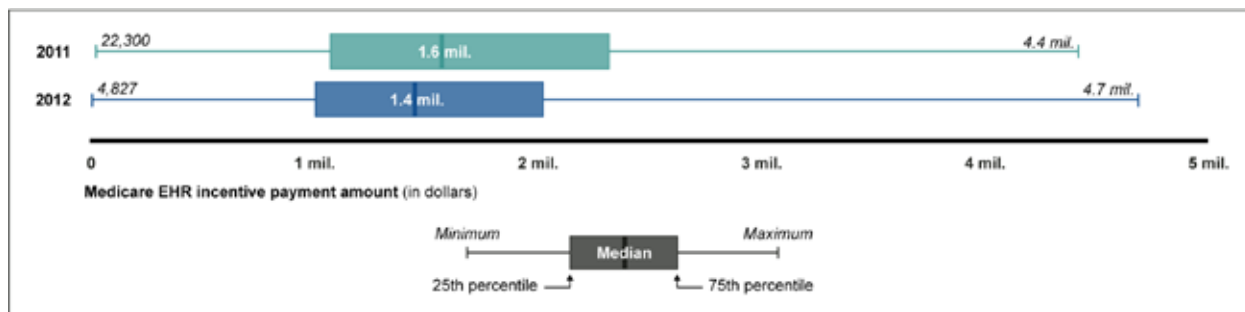
Nationwide, most of the hospitals (72 percent) that were awarded a Medicare EHR incentive payment for 2012 were new to the program—that is, they did not receive a payment for 2011. These hospitals make up 34 percent of eligible hospitals nationwide. Connecticut had the largest percentage (53 percent) of eligible hospitals awarded incentive payments that were new to the program for 2012.

Incentive payments to hospitals for 2012 ranged from a low of \$4,827 to a high of \$4.7 million. The median payment amount was \$1.4 million, a slight decrease from the median payment amount of \$1.6 million for 2011. (See fig. 1.) This is because most of the 28 percent of hospitals that were awarded a Medicare EHR incentive payment for 2012 received lower incentive payments for their second year of participation, as the formula reduces the potential incentive payment by 25 percent each year after an acute care hospital is first awarded a payment from the Medicare EHR program.¹⁸

¹⁷In contrast to professionals, certain hospitals may receive an incentive payment from both the Medicare and the Medicaid EHR programs in the same year. Through July 2, 2013, 1,686 hospitals were awarded an incentive payment from both programs for 2012 and 547 hospitals were awarded an incentive payment from both programs for 2011. In addition, for 2012, 32 hospitals were awarded a total of \$44 million in incentive payments from the Medicare Advantage Organization EHR program; and for 2011, 31 hospitals were awarded a total of \$51 million in incentive payments from the Medicare Advantage Organization EHR program.

¹⁸The payment calculation for critical access hospitals is not subject to the 25 percent annual reduction.

Figure 1: Distribution of Medicare EHR Incentive Payment Amounts Awarded to Hospitals



Source: GAO analysis of CMS data.

Note: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013.

Hospital characteristics. We found that the characteristics of hospitals that were awarded an incentive payment for 2012 were similar to the characteristics of hospitals awarded an incentive payment for 2011. Specifically among hospitals that were awarded an incentive payment for 2012, we found that

- the largest proportion (39 percent) was in the South, and the smallest proportion (15 percent) was in the West;
- about three-fifths (61 percent) were in urban areas;
- more than four-fifths (83 percent) were acute care hospitals; and
- three-fifths (60 percent) were nonprofit hospitals.

For 2012, hospitals with certain characteristics were more likely to have been awarded a Medicare EHR incentive payment than other hospitals. For example, hospitals in the Northeast were 1.5 times more likely than hospitals in the West to have been awarded an incentive payment. Further, acute care hospitals were nearly twice as likely as critical access hospitals to have been awarded an incentive payment. The largest hospitals—those in the top third in terms of numbers of beds—were 2 times more likely than hospitals in the bottom third to have been awarded an incentive payment.

Comparing 2012 to 2011, there were differences in the likelihood of hospitals with certain characteristics having been awarded incentive payments. For example, hospitals in rural areas were 3.1 times more likely to have been awarded an incentive payment for 2012 compared to 2011, which was a slightly greater increase than for hospitals overall.

Professional incentive payments. For 2012, 183,712 professionals were awarded a total of \$2.8 billion in Medicare EHR incentive payments.¹⁹ These 183,712 professionals awarded payments for 2012 represent 31 percent of the eligible professionals. They also represent an increase compared to 2011, when 58,331 professionals, or 10 percent of those eligible, were awarded an incentive payment. (See table 2.)

¹⁹For 2012, Medicare Advantage Organizations were awarded a total of \$135 million in incentive payments from the Medicare Advantage Organization EHR program for 11,340 professionals; and for 2011, a total of \$181 million in incentive payments from the Medicare Advantage Organization EHR program for 11,137 professionals.

Table 2: Participation in the Medicare EHR Program by Professionals

	2011	2012
Number (percentage of eligible)	58,331 (10)	183,712 (31)
Median payment	\$18,000	\$18,000
Total payments	\$994.6 million	\$2.8 billion

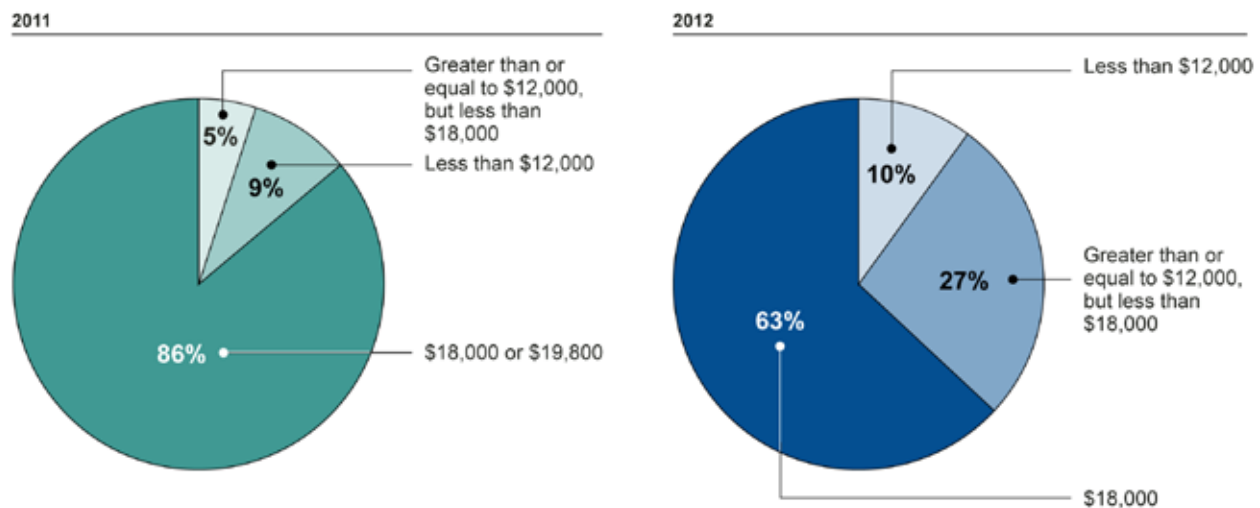
Source: GAO analysis of CMS data.

Note: Figures are based on data CMS collected through July 2, 2013, for the 2011 and 2012 program years.

Nationwide, most of the professionals (75 percent) who were awarded a Medicare EHR incentive payment for 2012 were new to the program. These professionals make up 23 percent of eligible professionals nationwide. South Dakota had the largest percentage (38 percent) of eligible professionals who were new to the program for 2012.

The percentage of professionals who received the highest Medicare EHR incentive payment amount (i.e., \$18,000 for 2012) decreased for 2012 compared to 2011. (See fig. 2.) This is because 2012 was the second year of participation for 25 percent of professionals and the maximum payment amount decreases over the 5 years in which professionals are eligible for payments.

Figure 2: Percentage of Professionals Who Were Awarded Medicare EHR Incentive Payments, by Amount



Source: GAO analysis of CMS data.

Note: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. The amount of the incentive payment for 2011 and 2012 cannot exceed \$18,000 for most professionals or \$19,800 for professionals who practice predominately in a health professional shortage area. The 2012 figure does not include the 10 percent additional payments for professionals who practice predominately in a health professional shortage area because CMS had not disbursed those payments as of the date of our analysis.

Professional characteristics. We found that the characteristics of professionals who were awarded an incentive payment for 2012 were similar to the characteristics of professionals awarded an incentive payment for 2011. Specifically, among professionals who were awarded an incentive payment for 2012, we found that

- the largest proportion (32 percent) was in the South, and the smallest proportion (18 percent) was in the West;

- a significant majority (90 percent) was in urban areas;
- over half (56 percent) were specialty practice physicians, and over one-third (34 percent) were general practice physicians;
- about half (44 percent) had relatively high amounts of 2012 Medicare Part B charges.

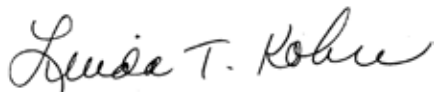
For 2012, professionals with certain characteristics were more likely to have been awarded a Medicare EHR incentive payment than other professionals. For example, general practice physicians were 1.5 times more likely than specialty practice physicians to have been awarded an incentive payment. Professionals who had signed an agreement to receive technical assistance from a Regional Extension Center were 1.9 times more likely to have been awarded an incentive payment than those who had not. Professionals in the top third in terms of Medicare Part B charges or number of Medicare Part B encounters were approximately 2.5 times more likely to have been awarded an incentive payment compared to those in the bottom third for charges or number of encounters.

Comparing 2012 to 2011, there were differences in the likelihood of professionals with certain characteristics having been awarded incentive payments. For example, professionals with the lowest total amount of Medicare Part B charges were 3.3 times more likely to have been awarded an incentive payment for 2012 compared to 2011, which was a slightly greater increase than for professionals overall.

See enclosure II for more information on the characteristics of hospitals that were awarded a Medicare EHR incentive payment for 2012, including comparisons to those awarded payments for 2011. See enclosure III for more information on the characteristics of professionals who were awarded a Medicare EHR incentive payment for 2012, including comparisons to those awarded payments for 2011.

We provided a draft of this report to the Department of Health and Human Services for comment. In its response, the department stated that it had no comments.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of CMS, the National Coordinator for Health Information Technology, and other interested parties. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>. If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at kohnl@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Major contributors to this report were William Simerl, Assistant Director; Julianne Flowers; Shannon Legeer; Hannah Marston Minter; Monica Perez Nelson; and Rebecca Rust Williamson.



Linda T. Kohn
Director, Health Care

Enclosures – 3

List of Committees

The Honorable Max Baucus
Chairman

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Tom Harkin
Chairman

The Honorable Lamar Alexander
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Tom Harkin
Chairman

The Honorable Jerry Moran
Ranking Member
Subcommittee on Labor, Health and Human Services, Education,
and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Fred Upton
Chairman

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Dave Camp
Chairman

The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

The Honorable Jack Kingston
Chairman

The Honorable Rosa DeLauro
Ranking Member
Subcommittee on Labor, Health and Human Services, Education,
and Related Agencies
Committee on Appropriations
House of Representatives

Scope and Methodology

This enclosure provides additional details regarding our analysis of data from the Centers for Medicare & Medicaid Services (CMS) and other government sources to (1) determine the number of providers that were awarded a Medicare electronic health record (EHR) incentive payment; (2) estimate the percentage of eligible providers that were awarded a Medicare EHR incentive payment; (3) determine the amount of Medicare EHR incentive payments awarded to providers; and (4) examine the characteristics of providers that were awarded Medicare EHR incentive payments. In addition, this enclosure provides information on the analysis we conducted to present information on Medicare Advantage Organization (MAO) payments.¹

Number of providers that were awarded a Medicare EHR incentive payment. To determine the number of providers that were awarded an incentive payment, we analyzed data on providers that were awarded Medicare EHR incentive payments for 2011 and 2012 from CMS's National Level Repository.² We analyzed data related to the 2011 and 2012 program years that CMS collected from January 3, 2011, through July 2, 2013. As a result, we generally included full-year information for both years in our analysis, since the second program year for hospitals ended on November 30, 2012, and the second program year for professionals ended on February 28, 2013.³ Specifically, we counted the number of providers that had an incentive payment disbursed to them.

Estimate of the percentage of eligible providers that were awarded a Medicare EHR incentive payment. To estimate the nationwide percentage of eligible providers that were awarded an incentive payment in each year, we divided the number of providers that were awarded an incentive payment in the year by the total number of eligible providers in the same year. We identified eligible hospitals as those that fit the following four criteria:

- were acute care hospitals or critical access hospitals;
- were located in one of the 50 states or the District of Columbia;
- were not terminated from participating in the Medicare program before October 1, 2010, for determining eligibility for 2011; or before October 1, 2011, for determining eligibility for 2012; and

¹In this report, we refer to the incentive program for Medicare fee-for-service as the Medicare EHR program and, where noted, the incentive program for Medicare Advantage as the MAO EHR program.

²The National Level Repository is a database that contains information on providers pertaining to the Medicare EHR program, including information on providers that are registered for the incentive program, whether those providers have met program requirements to receive an incentive payment, and the amount of incentive payments, if applicable. The National Level Repository also contains some information on providers pertaining to the Medicaid EHR program, which we generally did not include in our analysis.

³The total number of providers that received Medicare EHR incentive payments for 2011 or 2012 and the total amount of incentive payments awarded for either year could change due to provider audits or appeals. Additionally, our estimates for 2012 do not reflect the additional incentive payments that will be awarded to professionals who predominately furnished services in geographic areas designated as a health professional shortage area because CMS had not disbursed these amounts as of July 2, 2013. Health professional shortage areas are areas designated by the Health Resources and Services Administration as having shortages of primary medical care, dental, or mental health providers.

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- were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year.⁴

We identified eligible professionals as those that fit the following five criteria:

- have specialty types that are eligible for the Medicare EHR program, which include all medical doctor/doctor of osteopathic medicine specialties, chiropractors, doctors of dental medicine or surgery, podiatrists, and optometrists;
- were not hospital-based professionals;
- had greater than \$0 in Medicare Part B charges in 2010 for determining eligibility for 2011 or had greater than \$0 in Medicare Part B charges in 2011 for determining eligibility for 2012;
- were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year; and
- were not awarded an incentive payment from the Medicaid EHR program during the same year.⁵

We used a similar approach to estimate the percentage of eligible providers that were awarded an incentive payment for 2012 in each state. For those providers we also determined whether or not they were awarded a Medicare EHR payment for 2011.

Amount of Medicare EHR incentive payments awarded to providers. We determined the total amount of the incentive payments that were awarded to providers each year by summing the Medicare EHR incentive payments that had been disbursed by CMS in each year. We also examined the distribution of the Medicare incentive payments across providers. Specifically, for hospitals, we determined the minimum, 25th percentile, median, 75th percentile, and maximum Medicare EHR incentive payment amounts. For professionals, we determined the percentage who were awarded an incentive payment amount of (a) greater than or equal to \$18,000, but

⁴Acute care hospitals are hospitals described in Section 1886(d) of the Social Security Act, which are paid under the inpatient prospective payment system. The hospitals classified as critical access hospitals typically are very small (25 inpatient beds or fewer) and operate in rural areas.

Hospitals are not permitted to earn an incentive from the Medicare EHR program and the MAO EHR program during the same year. Hospitals that are affiliated with an MAO are hospitals described in Section 1886(d) of the Social Security Act, which are under common corporate governance with a qualifying MAO and for which at least two-thirds of their discharges are of individuals enrolled under Medicare Advantage plans. 42 C.F.R. § 495.200.

⁵CMS defines hospital-based professionals as those who furnish 90 percent or more of their services in either an inpatient or an emergency department of a hospital. We determined whether professionals were hospital-based by using electronic data files provided by CMS that indicated for specific professionals whether 90 percent or more of their Medicare services in 2010 were provided in an inpatient or emergency department of a hospital for determining eligibility in 2011 or whether 90 percent or more of their Medicare services in 2011 were provided in an inpatient or emergency department of a hospital for determining eligibility for 2012.

Medicare Part B charges refers to “allowed charges” set by Medicare that determine the amount of payments received by professionals for physician, outpatient hospital, home health care, and certain other services.

Professionals are not permitted to earn an incentive payment from the Medicare EHR program the same year an MAO receives an incentive payment from the MAO EHR program for the same professional.

Professionals are not permitted to earn an incentive from the Medicare EHR program and the Medicaid EHR program during the same year.

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less than or equal to \$19,800, (b) less than \$18,000 but greater than or equal to \$12,000, and (c) less than \$12,000.⁶

Characteristics of providers that were awarded Medicare EHR incentive payments. To examine the characteristics of providers that were awarded Medicare EHR incentive payments for 2011 and 2012, we analyzed data on provider characteristics from CMS, the Health Resources and Services Administration, and the Office of the National Coordinator for Health Information Technology (ONC). (See table 3.) Each characteristic is divided into two or more categories. For example, the characteristic “geographic region” is divided into four categories—Midwest, Northeast, South, and West regions. As part of this analysis, we also compared the characteristics of providers that were awarded a Medicare EHR incentive payment in a given year to those of eligible providers that were not awarded such payments in the same year. To do so, we calculated relative risk ratios that indicate how much more likely a provider in each category was to have been awarded an EHR incentive payment in a given year than a provider in the category that was least likely to have been awarded a payment in the same year.

⁶Although the maximum incentive payment for 2012 that could be awarded to professionals practicing in a health professional shortage area was \$19,800, our estimates for 2012 do not include the additional incentive payments for professionals who practice predominately in a health professional shortage area because CMS had not disbursed these amounts as of the date of our analysis.

Table 3: Data Sources Analyzed to Examine Characteristics of Eligible Providers

Agency or entity	Data source	Date of extract, download, or release for 2011	Date of extract, download, or release for 2012
CMS	National Level Repository	July 2013	July 2013
	2010 and 2011 Medicare Part B claims	January – December 2010	January – December 2011
	National Plan and Provider Enumeration System Data Dissemination File ^a	May 2012	January 2013
	Provider Enrollment, Chain, and Ownership System ^a	August 2012	April 2013
	Provider of Services File	January 2012	March 2013
	Hospital Compare	January 2013	January 2013
	Healthcare Cost Report Information System	March and June 2013 ^b	March and June 2013 ^b
	Integrated Data Repository	April 2013 ^c	April 2013 ^c
	2010 and 2011 Primary Care Health Professional Shortage Areas	November 2010	July 2012
Health Resources and Services Administration	Area Resource File	March 2012	March 2012
Office of the National Coordinator for Health Information Technology	Regional Extension Center Customer Relationship Management System extract file ^d	April 2013 ^e	April 2013 ^e
	List of zip codes serviced by a Beacon Community ^f	March 2012	April 2013

Source: GAO.

^aData contained in this data source are generally self-reported by providers to CMS.

^bWe combined the data obtained in the two extracts. For 2011 we used the most recent record for a hospital with a cost report end date prior to May 1, 2012, and for 2012 we used the most recent record available.

^cThe 2011 file is based on Medicare Part B claims from fiscal year 2010 (October 1, 2009, to September 30, 2010), and the 2012 file is based on Medicare Part B claims from fiscal year 2011 (October 1, 2010, to September 30, 2011).

^dThe Regional Extension Center program was established by the Health Information Technology for Economic and Clinical Health Act and is administered by the Office of the National Coordinator for Health Information Technology to help some types of providers, such as those located in rural areas, to participate in CMS's EHR programs.

^eFor 2011, we categorized professionals as having signed an agreement if they did so before January 1, 2012. For 2012, we categorized professionals as having signed an agreement if they did so before January 1, 2013.

^fThe Office of the National Coordinator for Health Information Technology provided funding to support 17 Beacon Communities to build and strengthen their health information technology infrastructure and exchange capabilities. These communities were selected for various reasons, including the progress they had already made in adopting EHRs. The 17 Beacon Communities focus on specific and measurable improvement goals in three areas for health systems improvement—quality, cost-efficiency, and population health—to demonstrate the ability of health information technology to affect local health care systems.

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Using the data obtained from the sources listed in table 3, we examined the following provider characteristics:

- *Regional characteristics.* We analyzed data on the following regional characteristics:⁷
 - *Geographic region.* We used the Health Resources and Services Administration’s Area Resource File to identify the U.S. census region—Midwest, Northeast, South, or West—where providers were located or practiced.
 - *Location.* We used the Health Resources and Services Administration’s Area Resource File to determine whether providers were located in a metropolitan area—an area that has at least one urbanized area of 50,000 people. We then categorized providers in metropolitan areas as being located in urban areas and providers that were not as being in rural areas.
 - *Whether a provider is in a county with a Beacon Community.* We used data from ONC to categorize providers as either being in a Beacon Community or not.⁸
 - *Whether a professional practices in a health professional shortage area.* We used the list from CMS that identifies the zip codes that were designated as primary care health professional shortage areas for bonus payments to categorize providers as either being in a health professional shortage area or not.⁹
- *Hospital type.* We analyzed data on the following categorizations of hospital type:
 - *Hospital classification.* We determined whether hospitals were classified as acute care hospitals or critical access hospitals by using data from CMS’s Provider of Services file.
 - *Major teaching hospital.* We determined whether or not hospitals were listed as having a major affiliation with a medical school in CMS’s Provider of Services file.
 - *Ownership type.* We used data on ownership type from CMS’s Provider of Services file to create three categories of ownership: (a) for-profit by combining private for-profit and physician ownership, (b) nonprofit by combining church and private not-for-profit, and (c) government-owned by combining four government designations (federal, state, local, and hospital district or authority) and tribal. In instances in which ownership type was listed as “other” in the Provider of Services file, we obtained information needed to

⁷In most cases, in order to link the information from these files to individual providers, we obtained zip codes and county-level Federal Information Processing Standard codes for hospital locations from CMS’s Provider of Services file and zip codes for professional practice locations from CMS’s Provider Enrollment, Chain, and Ownership System and CMS’s National Plan and Provider Enumeration System. With the assistance of a zip code to Federal Information Processing Standard code crosswalk file that we obtained from CMS, we were able to determine the counties in which professionals practiced. When zip codes or county codes could not be determined, we were able to use state information to analyze information on geographic region.

⁸ONC provided funding to support 17 Beacon Communities to build and strengthen their health information technology infrastructure and exchange capabilities. These communities were selected for various reasons, including the progress they had already made in adopting EHRs. The 17 Beacon Communities focus on specific and measurable improvement goals in three areas for health systems improvement—quality, cost-efficiency, and population health—to demonstrate the ability of health information technology to affect local health care systems.

⁹CMS’s list of zip codes for health professional shortage areas does not contain zip codes that were only partially in a shortage area.

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classify hospitals as for-profit, nonprofit, or government-owned from another CMS data source—Hospital Compare.

- *Chain membership.* We categorized hospitals as being a member of a chain if the hospital has a chain home office listed in CMS's Provider Enrollment, Chain, and Ownership System. All other hospitals with a record in CMS's Provider Enrollment, Chain, and Ownership System were designated as not being a member of a chain.¹⁰
- *Hospital size.* We analyzed the following measures of hospital size from CMS's Provider of Services file and Healthcare Cost Report Information System:¹¹
 - *Total beds.* Using data from CMS's Provider of Services file on the total number of hospital beds, we created three categories for each year: (a) low—less than or equal to the 33.3rd percentile, (b) middle—greater than the 33.3rd percentile but less than or equal to the 66.7th percentile, and (c) high—greater than the 66.7th percentile.
 - *Medicare inpatient bed days.* Using data from CMS's Healthcare Cost Report Information System, for each hospital we counted the number of Medicare inpatient bed days.¹² Using these aggregated data, we created three categories for each year, utilizing the same percentile-based methodology used to categorize total beds.
 - *Total discharges.* Using data from CMS's Healthcare Cost Report Information System on the total number of discharges for each hospital, we created three categories for each year, utilizing the same percentile-based methodology used to categorize total beds.
- *Hospital charges.* We analyzed data on the following measures of hospital charges from CMS's Healthcare Cost Report Information System:
 - *Total charges.* Using data on the total amount of charges, we created three categories for each year, utilizing the same percentile-based methodology used to categorize total beds.¹³
 - *Charity charges.* Using data on charity charges, we created three categories for each year, utilizing the same percentile-based methodology used to categorize total beds.¹⁴

¹⁰Information on chain membership was missing for 255 eligible hospitals for 2011 (5 percent) and 143 eligible hospitals for 2012 (3 percent).

¹¹For the data obtained from the Healthcare Cost Report Information System, for 2011 we used the most recent record for a hospital with a cost report end date prior to May 1, 2012, and for 2012 we used the most recent record available.

¹²We dropped data if the data were potentially unreliable—that is, if the number of Medicare inpatient bed days exceeded the total number of inpatient bed days.

¹³We excluded data from our analysis of total charges and charity charges if we determined that the hospitals' data were unreliable because the amount of charity charges exceeded the total amount of charges.

¹⁴Charity charges reflect the cost of providing inpatient and outpatient hospital services for which the hospital is not compensated. Information on charity charges was missing for 622 eligible hospitals (13 percent) for 2011 and for 544 eligible hospitals (11 percent) for 2012.

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- *Professional characteristics.* We included in our analysis the following four types of professional characteristics:
 - *Professional specialty.* We primarily obtained data on professionals' primary specialty from CMS's National Plan and Provider Enumeration System Downloadable File. Then, with the assistance of a crosswalk that we obtained from CMS that aggregates specialty taxonomy codes into a smaller number of specialties, we created the following six categories: (a) general practice physician, (b) specialty practice physician, (c) chiropractor, (d) dentist, (e) optometrist, and (f) podiatrist.¹⁵ In instances in which the professional specialty information was missing from the National Plan and Provider Enumeration System, we obtained information on professionals' specialty from another CMS data source—the Provider Enrollment, Chain, and Ownership System. To examine variation among different types of specialty practice physicians, we used information from the CMS crosswalk to assign specialty practice physicians to one of 27 specialty categories, such as cardiology, surgery, and psychiatry. Professionals who had missing information on professional specialty in both data sources and had not been awarded a Medicare EHR incentive payment for 2011 or 2012 were dropped from our analysis for the respective year, since we were unable to determine whether they were eligible to receive an incentive payment.¹⁶
 - *Whether the professional had signed an agreement to receive technical assistance from a Regional Extension Center.* We obtained data from ONC's Regional Extension Center Customer Relationship Management System on whether professionals (identified by National Provider Identifier) had signed an agreement to receive technical assistance from a Regional Extension Center.¹⁷ We then categorized professionals as either having signed an agreement to receive technical assistance or not. For 2011, we categorized professionals as having signed an agreement if they did so before January 1, 2012. For 2012, we categorized professionals as having signed an agreement if they did so before January 1, 2013.
 - *Years since the professional's degree was awarded.* Using data on when professionals had received their degree from CMS's Provider Enrollment, Chain, and Ownership System, we determined the number of years since each professional's degree was awarded.¹⁸ We subsequently created three categories: (a) low—less than or equal to

¹⁵We classified doctors of medicine and osteopathic medicine that specialize in family practice, general practice, or internal medicine as general practice physicians; all other doctors of medicine and osteopathic medicine were classified as specialty practice physicians.

¹⁶We were unable to classify 45 professionals awarded a Medicare EHR incentive payment for 2011 and 90 professionals awarded an incentive payment for 2012 (less than 1 percent of those awarded payments each year) into one of our specialty categories.

¹⁷The Regional Extension Center program was established by the Health Information Technology for Economic and Clinical Health Act and is administered by ONC to help some types of providers, such as those in rural areas, to participate in CMS's EHR programs.

¹⁸We dropped data on years since the professional's degree was awarded if the data were potentially unreliable—that is, if the number of years exceeded 75.

15 years, (b) middle—greater than 15 years but less than or equal to 29 years, and (c) high—30 years or more.¹⁹

- *Professional practice size.* We analyzed data on the following three measures of practice size from CMS's calendar year 2010 Medicare Part B claims or 2011 Medicare Part B claims:²⁰
 - *Total amount of Medicare Part B charges.* For each professional (identified by National Provider Identifier), we summed the amount of Medicare Part B charges over the year. For 2011 we used 2010 claims, and for 2012 we used 2011 claims. Subsequently, we created three categories by aggregating total charges by professional for each year, utilizing the same percentile-based methodology used to categorize total beds.²¹
 - *Total number of Medicare Part B encounters.* For each professional (identified by National Provider Identifier), we counted the number of Medicare Part B encounters—that is, distinct Medicare patient visits. For 2011 we used 2010 claims, and for 2012 we used 2011 claims. Subsequently, we created three categories by aggregating total encounters by professional for each year, utilizing the same percentile-based methodology used to categorize total beds.²²
 - *Number of professionals in the practice.* We estimated the number of professionals in each practice by counting the number of professionals who were listed as members of each professional practice in CMS's Provider Enrollment, Chain, and Ownership System. We subsequently created four practice size categories: (a) solo practice, (b) practice of 2 to 10 professionals, (c) practice of 11 to 50 professionals, and (d) practice of 51 or more professionals. We also created a fifth category for professionals who were associated with more than one group practice of different sizes.²³

Number of providers that were awarded a Medicare Advantage Organization (MAO) EHR incentive payment and the amount of MAO EHR incentive payments awarded. To determine the number of providers that were awarded an MAO EHR incentive payment and total amount of payments awarded, we analyzed data related to the 2011 and 2012 program years that CMS collected from January 3, 2011, through July 2, 2013, in its National Level Repository. Specifically, we counted the number of providers that had an MAO EHR incentive

¹⁹Information on the number of years since the professional's degree was awarded was missing for 27,076 eligible professionals (5 percent) for 2011 and 14,613 eligible professionals (2 percent) for 2012.

²⁰Information on Medicare Part B claims was missing for 1,399 professionals who were awarded a Medicare EHR incentive payment (2 percent) for 2011 and for 4,826 professionals who were awarded a Medicare EHR incentive payment (3 percent) for 2012.

²¹Percentiles were created using information on Medicare Part B charges for all professionals who had greater than \$0 in charges for the year.

²²Percentiles were created using information on Medicare Part B encounters for all professionals who had at least one encounter for the year.

²³Information on the number of professionals in the practice was missing for 85,455 eligible professionals (15 percent) for 2011 and for 75,177 eligible professionals (13 percent).

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payment disbursed to them, and we summed the MAO EHR incentive payments that had been disbursed in each year.²⁴

In July 2012 we reported information on providers that were awarded Medicare EHR incentive payments for 2011, including the number of award recipients and their characteristics.²⁵ In constructing the analyses for this report, we made some refinements to the methodology utilized in the July 2012 report.²⁶ For example, we analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013, which includes payments made for both 2011 and 2012. In addition, we used data from CMS's Healthcare Cost Report Information System instead of from CMS's Fiscal Intermediary Standard System to present the following information for hospitals: Medicare inpatient bed days, total discharges, total charges, and charity charges. We made this change to reduce the number of hospitals for which we were missing data. We also excluded from the counts of eligible hospitals (presented in enclosure II) those hospitals that received incentive payments from the MAO EHR program. In addition, we excluded from the counts of eligible professionals (presented in enclosure III) professionals affiliated with MAOs that received incentive payments from the MAO EHR program and professionals that received incentive payments from the Medicaid EHR program.²⁷ We made these changes to better reflect the population of providers who were eligible for the Medicare EHR program in the given year.

To ensure the reliability of the various data we analyzed, we interviewed officials from CMS and ONC; reviewed relevant documentation; and conducted electronic testing to identify missing data and obvious errors. On the basis of these activities, we determined that the data we analyzed were sufficiently reliable for our analysis. Although the amount of missing data was generally low, we noted instances in which data were missing for 6 percent of providers or more.

We conducted this performance audit from April 2013 to October 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

²⁴For hospitals, the MAO EHR incentive payment amount for any given year is generally based on the hospital's annual discharges and Medicare share, which is the percentage of the hospital's inpatient bed days that were attributable to Medicare patients. For professionals, the amount of MAO EHR incentive payment in any given year is generally based on the professional's revenue for services provided to Medicare Advantage plan enrollees of a qualifying MAO, subject to an annual limit. For professionals first participating in 2012, the amount of the incentive payment for 2012 could not exceed \$18,000. For professionals first participating in 2011, the amount of the incentive payment for 2012 could not exceed \$12,000.

²⁵See GAO, *Electronic Health Records: Number and Characteristics of Providers Awarded Medicare Incentive Payments for 2011*, [GAO-12-778R](#) (Washington, D.C.: July 26, 2012).

²⁶We also excluded some data sources from this report that were analyzed in the July 2012 report.

²⁷The counts of eligible professionals in our July 2012 report generally excluded professionals affiliated with MAOs.

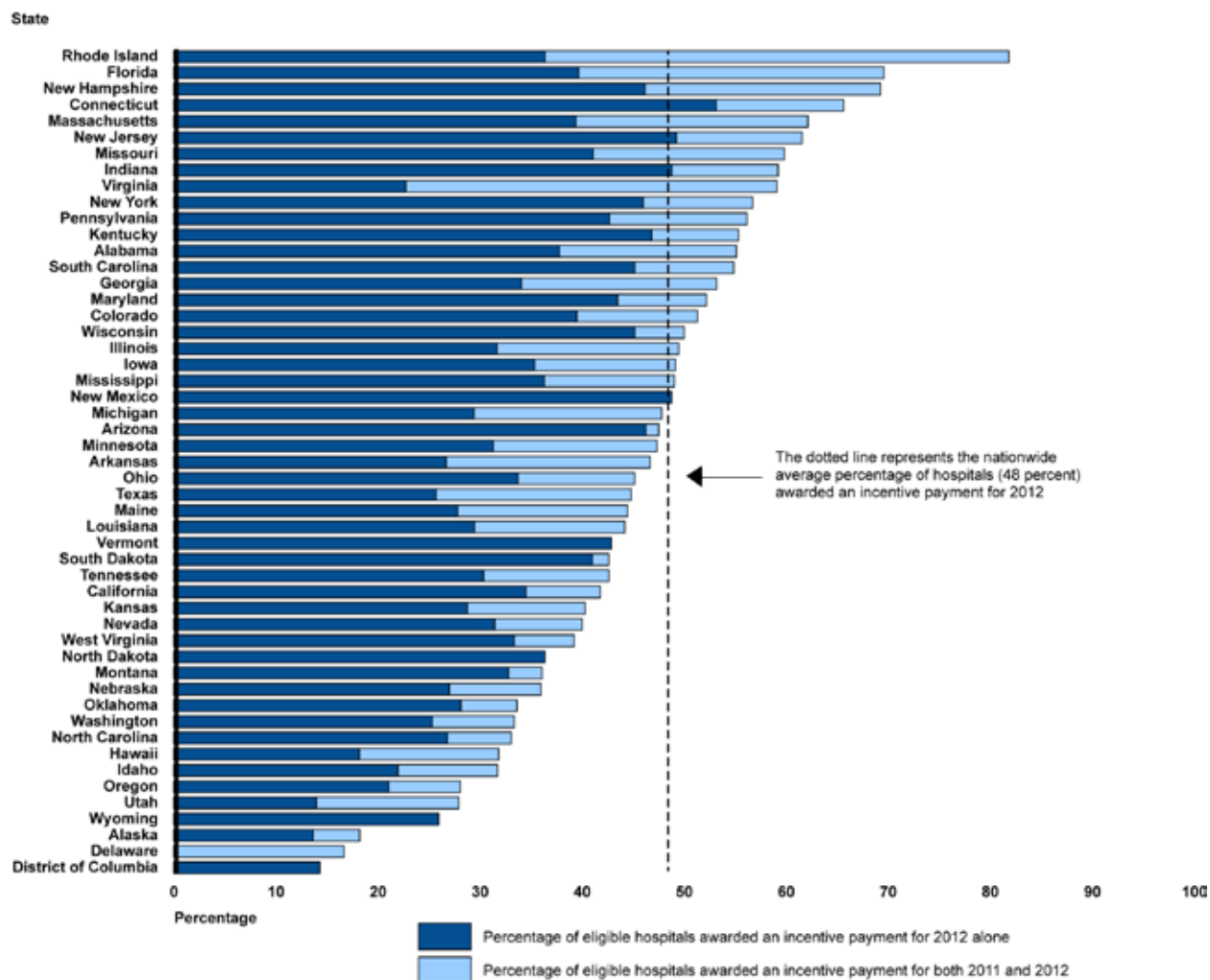
**Information on Hospitals That Were Awarded Medicare
EHR Incentive Payments for 2012 and 2011**

This enclosure provides information on the amount of Medicare EHR incentive payments awarded to hospitals for 2012, the number and percentage of hospitals that were awarded incentive payments, and the characteristics of hospitals that were awarded incentive payments. This enclosure also compares different categories of eligible hospitals to determine which were more likely and which were less likely for 2012 to have been awarded an incentive payment. In some cases, information on Medicare EHR incentive payments awarded to hospitals for 2011 is presented for comparison. In addition, this enclosure compares the characteristics of hospitals awarded incentive payments for 2012 to the characteristics of hospitals awarded incentive payments for 2011.

Of the estimated 4,806 eligible hospitals, 48 percent, or 2,291 hospitals, were awarded a Medicare EHR incentive payment for 2012.¹ The percentage of eligible hospitals that were awarded a Medicare EHR incentive payment varied by state for 2012. For example, more than 80 percent of eligible hospitals in Rhode Island were awarded a Medicare EHR incentive payment for 2012, whereas less than 15 percent of eligible hospitals in the District of Columbia were awarded an incentive payment for 2012. In 18 states, the percentage of eligible hospitals that received incentive payments for 2012 was 50 percent or more (see fig. 3).

¹In contrast to professionals, certain hospitals may receive an incentive payment from both the Medicare and Medicaid EHR programs in the same year. Through July 2, 2013, 1,686 hospitals were awarded an incentive payment from both programs for 2012.

Figure 3: Percentage of Eligible Hospitals That Were Awarded a Medicare EHR Incentive Payment for 2012 Alone and for Both 2011 and 2012, by State



Source: GAO analysis of CMS data.

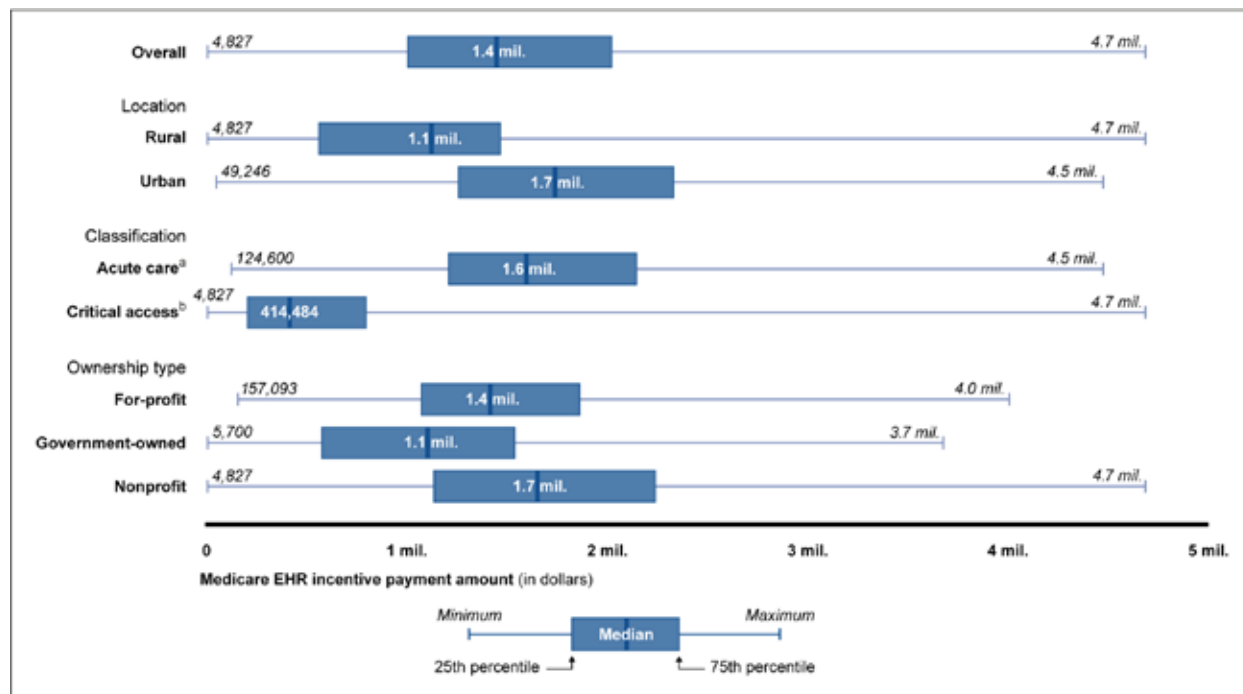
Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. This figure illustrates the percentage of eligible hospitals that were awarded Medicare EHR incentive payments for 2012 by state, as indicated in the full length of each bar. These bars are divided to indicate the percentage of eligible hospitals that were awarded an incentive payment only for 2012, designated by the darker shading, and the percentage of eligible hospitals that were awarded an incentive payment for both 2011 and 2012, designated by the lighter shading. No hospitals in the District of Columbia received payments for 2011.

Nationwide, most of the hospitals (72 percent) that were awarded a Medicare EHR incentive payment for 2012 were new to the program—that is, they did not receive a payment for 2011—with substantial variation among states. These hospitals make up 34 percent of eligible hospitals nationwide. Connecticut had the largest percentage (53 percent) of eligible hospitals that were new to the Medicare EHR incentive program for 2012, meaning they did not receive a payment for 2011. Additionally, almost all hospitals that received Medicare EHR incentive payments for 2012 in Arizona were new to the program for 2012. In contrast, less than half of the hospitals in Virginia that received incentive payments for 2012 were new to the program. While many hospitals were new to the program for 2012, 18 percent of the hospitals that were awarded a Medicare EHR incentive payment for 2011 were not awarded a payment for 2012.

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Of the \$6.3 billion in Medicare EHR incentive payments that were awarded to providers for 2012, a total of \$3.5 billion was awarded to hospitals. The amount of Medicare EHR incentive payments awarded to hospitals ranged from \$4,827 to \$4.7 million, with the median amount being \$1.4 million. Sixty percent of hospitals that were awarded an incentive payment accounted for 80 percent of the total amount of incentive payments awarded to hospitals. Acute care hospitals tended to receive larger incentive payments than critical access hospitals. (See fig. 4.)

Figure 4: Distribution of Medicare EHR Incentive Payment Amounts Awarded to Hospitals for 2012, by Selected Hospital Characteristics



Source: GAO analysis of CMS and Health Resources and Services Administration data.

Note: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013.

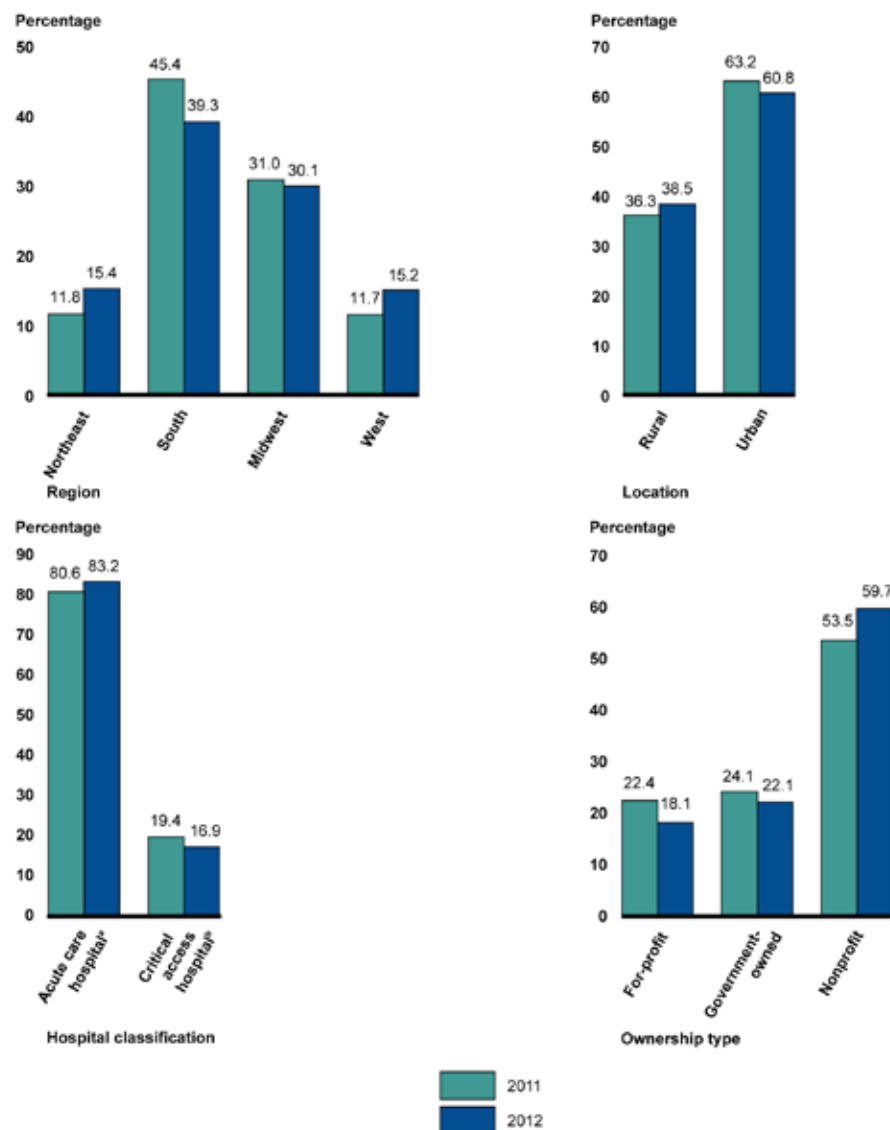
^aAcute care hospitals are hospitals described in Section 1886(d) of the Social Security Act, which are paid under the inpatient prospective payment system.

^bCritical access hospitals typically are very small (25 inpatient beds or fewer) and operate in rural areas.

As illustrated in figure 5, the characteristics among hospitals that were awarded a Medicare EHR incentive payment for 2012 are similar to those among hospitals awarded a Medicare EHR incentive payment for 2011. Specifically, for 2012,

- the largest proportion (39 percent) was in the South, and the smallest proportion (15 percent) was in the West;
- about three-fifths (61 percent) were in urban areas;
- more than four-fifths (83 percent) were acute care hospitals; and
- three-fifths (60 percent) were nonprofit hospitals.

Figure 5: Selected Characteristics of Hospitals That Were Awarded a Medicare EHR Incentive Payment for 2011 and 2012



Source: GAO analysis of CMS and Health Resources and Services Administration data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. For a given year, the sum of the percentages of hospitals listed for a given characteristic may not equal 100 percent due to missing data or rounding.

^aAcute care hospitals are hospitals described in Section 1886(d) of the Social Security Act, which are paid under the inpatient prospective payment system.

^bCritical access hospitals typically are very small (25 inpatient beds or fewer) and operate in rural areas.

Tables 4 through 7 compare the characteristics of hospitals that were awarded Medicare EHR incentive payments for 2012 and 2011 to those of other eligible Medicare hospitals that did not receive a payment for those years. Each characteristic is divided into two or more categories. For example, the characteristic “geographic region” is divided into four categories—Midwest, Northeast, South, and West. As part of this analysis, we calculated relative risk ratios that indicate how much more likely a hospital in each category was to have been awarded an EHR incentive payment in a given year than a hospital in the category that was least likely to have been awarded a payment for the same year. The categories in which hospitals were least likely

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to receive an incentive payment for the year are labeled “ – ”. For example, as table 4 shows, under the characteristic “geographic region” for 2012, the relative risk ratio of 1.5 for the category “Northeast” indicates that, for 2012, hospitals in the Northeast were 1.5 times more likely to have been awarded an incentive payment than hospitals in the West, which were the least likely to receive an incentive payment. A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories for the given year, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

Table 4 shows the relationship between hospitals receiving Medicare EHR incentive payments for 2012 and the regions in which the hospitals are located. We found the following:

- Geographic region had a modest effect on the likelihood that hospitals were awarded an EHR incentive payment for 2012. For instance, hospitals in the Northeast—the region with the highest percentage of hospitals awarded an incentive payment for 2012—were 1.5 times more likely to have been awarded a payment than hospitals in the West—the region with the lowest percentage of hospitals awarded an incentive payment in the same year.
- Urban or rural location also had a small effect on the likelihood that hospitals were awarded an EHR incentive payment for 2012. Specifically, for 2012, hospitals in urban areas were slightly (1.2 times) more likely to have been awarded a payment compared to hospitals in rural areas.

As indicated in table 4, the relationship between hospitals receiving Medicare EHR incentive payments and characteristics of the regions in which the hospitals are located is similar for both 2011 and 2012. However, the region where hospitals were most likely to receive an EHR incentive payment shifted from the South for 2011 to the Northeast for 2012.

Table 4: Number and Percentage of Hospitals That Were Awarded Medicare EHR Incentive Payments for 2011 and 2012, by Regional Characteristics

Characteristics	Categories	2011			2012		
		Number of eligible hospitals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b	Number of eligible hospitals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b
Overall		4,825	777 (16.1)	N/A	4,806	2,291 (47.7)	N/A
Geographic region	Midwest	1,460	241 (16.5)	1.6	1,454	689 (47.4)	1.2
	Northeast	607	92 (15.2)	1.5	608	353 (58.1)	1.5
	South	1,866	353 (18.9)	1.9	1,858	900 (48.4)	1.2
	West	892	91 (10.2)	—	886	349 (39.4)	—
Location	Rural	2,072	282 (13.6)	—	2,064	882 (42.7)	—
	Urban	2,723	491 (18.0)	1.3	2,714	1,393 (51.2)	1.2
Located in a county with a Beacon Community	Yes	295	43 (14.6)	—	281	131 (46.6)	—
	No	4,530	734 (16.2)	1.1	4,525	2,160 (47.7)	1.0

Source: GAO analysis of CMS, Office of the National Coordinator for Health Information Technology, and Health Resources and Services Administration data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the hospitals that were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible hospitals that were not awarded a payment in the same year. The sum of the number of hospitals listed by category may not equal the overall number of hospitals due to missing data.

^aWe use the term eligible hospitals to refer to those hospitals that were eligible for the Medicare EHR program, regardless of whether they were awarded a Medicare EHR incentive payment for 2011 and 2012. Specifically, eligible hospitals are those that were (1) acute care hospitals or critical access hospitals; (2) located in one of the 50 states or the District of Columbia; (3) were not terminated from participating in the Medicare program before October 1, 2010, for determining eligibility for 2011; or on or before October 1, 2011, for determining eligibility for 2012; and (4) were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year.

^bThe relative risk ratios indicate how much more likely a hospital in each category was to have been awarded an EHR incentive payment than a hospital in the category that was least likely to have been awarded a payment, which is labeled “—”. A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

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Table 5 shows the relationship between receiving a Medicare EHR incentive payment for 2012 and hospital type. We found the following:

- Hospital classification had a greater effect on the likelihood of receiving a Medicare EHR incentive payment for 2012 than being a major teaching hospital, ownership type, and chain membership. In particular, among the two hospital classifications, acute care hospitals were nearly twice as likely for 2012 to have been awarded an incentive payment than critical access hospitals.
- Being a major teaching hospital, ownership type, and chain membership had small effects on the likelihood that hospitals were awarded a Medicare EHR incentive payment for 2012. For example, major teaching hospitals were 1.3 times more likely to have received a payment than hospitals that were not major teaching hospitals.

The effects of hospital classification, being a major teaching hospital, and chain membership were generally similar for 2011 compared to for 2012. However, for 2012 the effect of hospital classification was greater than for 2011, and the effects associated with ownership type and chain membership largely disappeared.

Table 5: Number and Percentage of Hospitals That Were Awarded Medicare EHR Incentive Payments for 2011 and 2012, by Hospital Type

Characteristics	Categories	2011			2012		
		Number of eligible hospitals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b	Number of eligible hospitals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b
Overall		4,825	777 (16.1)	N/A	4,806	2,291 (47.7)	N/A
Hospital classification	Acute care hospital ^c	3,494	626 (17.9)	1.6	3,472	1,905 (54.9)	1.9
	Critical access hospital ^d	1,331	151 (11.3)	—	1,334	386 (28.9)	—
Major teaching hospital	Yes	427	88 (20.6)	1.3	429	266 (62.0)	1.3
	No	4,398	689 (15.7)	—	4,377	2,025 (46.3)	—
Ownership type	For-profit	840	174 (20.7)	1.4	846	415 (49.1)	1.1
	Government-owned	1,221	187 (15.3)	1.0	1,182	507 (42.9)	—
	Nonprofit	2,744	416 (15.2)	—	2,764	1,367 (49.5)	1.2
Chain membership	Chain	1,552	313 (20.2)	1.3	1,645	851 (51.7)	1.1
	Nonchain	3,018	454 (15.0)	—	3,018	1,419 (47.0)	—

Source: GAO analysis of CMS data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the hospitals that were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible hospitals that were not awarded a payment in the same year. The sum of the number of hospitals listed by category may not equal the overall number of hospitals due to missing data.

^aWe use the term eligible hospitals to refer to those hospitals that were eligible for the Medicare EHR program, regardless of whether they were awarded a Medicare EHR incentive payment for 2011 and 2012. Specifically, eligible hospitals are those that were (1) acute care hospitals or critical access hospitals; (2) located in one of the 50 states or the District of Columbia; (3) were not terminated from participating in the Medicare program before October 1, 2010, for determining eligibility for 2011; or on or before October 1, 2011, for determining eligibility for 2012; and (4) were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year.

^bThe relative risk ratios indicate how much more likely a hospital in each category was to have been awarded an EHR incentive payment than a hospital in the category that was least likely to have been awarded a payment, which is labeled “—”. A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

^cAcute care hospitals are hospitals described in Section 1886(d) of the Social Security Act, which are paid under the inpatient prospective payment system.

^dCritical access hospitals typically are very small (25 inpatient beds or fewer) and operate in rural areas.

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Table 6 shows the extent to which the size of hospitals, measured in various ways, is related to whether hospitals were awarded Medicare EHR incentive payments for 2012. We found that large hospitals were generally more likely to have been awarded a Medicare EHR incentive payment for 2012 than either small or medium-sized hospitals.

- Hospitals in the high and middle categories for number of total beds for 2012 were 2 and 1.8 times more likely, respectively, than hospitals in the low category to have been awarded an incentive payment.
- Hospitals in the high and middle categories for number of total discharges for 2012 were 1.9 and 1.6 times more likely, respectively, than hospitals in the low category to have been awarded an incentive payment.

For 2011, the relationship between hospital size and having been awarded an incentive payment was similar, but the magnitude of the differences was not as great. Thus large hospitals were even more likely to receive Medicare EHR incentive payments than small hospitals for 2012 than for 2011.

Table 6: Number and Percentage of Hospitals That Were Awarded Medicare EHR Incentive Payments for 2011 and 2012, by Hospital Size

Characteristics	Categories	2011			2012		
		Number of eligible hospitals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b	Number of eligible hospitals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b
Overall		4,825	777 (16.1)	N/A	4,806	2,291 (47.7)	N/A
Total beds ^c	Low	1,608	185 (11.5)	—	1,606	486 (30.3)	—
	Middle	1,609	265 (16.5)	1.4	1,552	827 (53.3)	1.8
	High	1,608	327 (20.3)	1.8	1,602	951 (59.4)	2.0
Medicare inpatient bed days ^d	Low	1,574	194 (12.3)	—	1,568	502 (32.0)	—
	Middle	1,572	255 (16.2)	1.3	1,567	815 (52.0)	1.6
	High	1,574	324 (20.6)	1.7	1,568	953 (60.8)	1.9
Total discharges ^e	Low	1,576	195 (12.4)	—	1,570	506 (32.2)	—
	Middle	1,577	248 (15.7)	1.3	1,570	805 (51.3)	1.6
	High	1,575	331 (21.0)	1.7	1,568	959 (61.2)	1.9

Source: GAO analysis of CMS data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the hospitals that were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible hospitals that were not awarded a payment in the same year. The sum of the number of hospitals listed by category may not equal the overall number of hospitals due to missing data.

^aWe use the term eligible hospitals to refer to those hospitals that were eligible for the Medicare EHR program, regardless of whether they were awarded a Medicare EHR incentive payment for 2011 and 2012. Specifically, eligible hospitals are those that were (1) acute care hospitals or critical access hospitals; (2) located in one of the 50 states or the District of Columbia; (3) were not terminated from participating in the Medicare program before October 1, 2010, for determining eligibility for 2011; or on or before October 1, 2011, for determining eligibility for 2012; and (4) were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year.

^bThe relative risk ratios indicate how much more likely a hospital in each category was to have been awarded an EHR incentive payment than a hospital in the category that was least likely to have been awarded a payment, which is labeled “—”. A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

^cFor total beds, the ranges were as follows: for 2011, low—less than or equal to 38; middle—greater than 38 but less than or equal to 173; and high—greater than 173; and for 2012, low—less than or equal to 39; middle—greater than 39 but less than or equal to 174; and high—greater than 174.

^dFor Medicare inpatient bed days, the ranges were as follows: for 2011, low—less than or equal to 3,611; middle—greater than 3,611 but less than or equal to 26,353; and high—greater than 26,353; and for 2012, low—less than or equal to 3,493; middle—greater than 3,493 but less than or equal to 25,915; and high—greater than 25,915.

^eFor total discharges, the ranges were as follows: for 2011, low—less than or equal to 1,091; middle—greater than 1,091 but less than or equal to 6,586; and high—greater than 6,586; and for 2012, low—less than or equal to 1,072; middle—greater than 1,072 but less than or equal to 6,471; and high—greater than 6,471.

Table 7 shows the relationship between receiving Medicare EHR incentive payments for 2012 and the amounts of total charges and of charity charges. We found the following:

- The amount of total charges had an effect on the likelihood that hospitals were awarded an EHR incentive payment for 2012. For example, for 2012, hospitals in the middle and high categories for total charges were 1.4 and 1.8 times more likely, respectively, to have been awarded an incentive payment than hospitals in the low category.
- Hospitals in the high category for charity charges were more likely to receive a Medicare EHR incentive payment for 2012 compared to hospitals in the low category. Specifically, for 2012, hospitals in the middle or high categories were 1.3 and 1.6 times more likely, respectively, to have been awarded an incentive payment than hospitals in the low category.

For 2011 the relationship between charity charges and whether hospitals were awarded Medicare EHR incentive payments was similar. However, the relationship between total charges and receiving a Medicare EHR incentive payment was different for 2011. Specifically, for 2011, hospitals in the high category for total charges were more likely to receive a payment than hospitals in either the middle or the low categories. In contrast, for 2012, the high and middle categories had a greater likelihood of receiving a payment compared to the low category.

Table 7: Number and Percentage of Hospitals That Were Awarded Medicare EHR Incentive Payments for 2011 and 2012, by Hospital Charges

Characteristics	Categories	2011			2012		
		Number of eligible hospitals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b	Number of eligible hospitals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b
Overall		4,825	777 (16.1)	N/A	4,806	2,291 (47.7)	N/A
Total charges ^c	Low	1,576	216 (13.7)	1.0	1,570	539 (34.3)	—
	Middle	1,580	212 (13.5)	—	1,574	761 (48.3)	1.4
	High	1,576	344 (21.8)	1.6	1,570	970 (61.8)	1.8
Charity charges ^d	Low	1,400	204 (14.6)	—	1,420	545 (38.4)	—
	Middle	1,403	235 (16.7)	1.1	1,422	722 (50.8)	1.3
	High	1,400	297 (21.2)	1.5	1,420	861 (60.6)	1.6
	Missing ^e	622	41 (6.6)	N/A	544	163 (30.0)	N/A

Source: GAO analysis of CMS data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the hospitals that were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible hospitals that were not awarded a payment in the same year. The sum of the number of hospitals listed by category may not equal the overall number of hospitals due to missing data.

^aWe use the term eligible hospitals to refer to those hospitals that were eligible for the Medicare EHR program, regardless of whether they were awarded a Medicare EHR incentive payment for 2011 and 2012. Specifically, eligible hospitals are those that were (1) acute care hospitals or critical access hospitals; (2) located in one of the 50 states or the District of Columbia; (3) were not terminated from participating in the Medicare program before October 1, 2010, for determining eligibility for 2011; or on or before October 1, 2011, for determining eligibility for 2012; and (4) were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year.

^bThe relative risk ratios indicate how much more likely a hospital in each category was to have been awarded an EHR incentive payment than a hospital in the category that was least likely to have been awarded a payment, which is labeled “—”. A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

^cFor total charges, the ranges were as follows: for 2011, low—less than or equal to \$61,333,788; middle—greater than \$61,333,788 but less than or equal to \$375,676,705; and high—greater than \$375,676,705; and for 2012, low—less than or equal to \$63,732,912; middle—greater than \$63,732,912 but less than or equal to \$388,812,277; and high—greater than \$388,812,277.

^dCharity charges reflect the cost for providing inpatient and outpatient hospital services for which the hospital is not compensated. For charity charges, the ranges were as follows: for 2011, low—less than or equal to \$1,044,578; middle—greater than \$1,044,578 but less than or equal to \$8,861,923; and high—greater than \$8,861,923; and for 2012, low—less than or equal to \$1,052,181; middle—greater than \$1,052,181 but less than or equal to \$9,222,248; and high—greater than \$9,222,248.

^eInformation on charity charges was missing for 622 eligible hospitals (13 percent) for 2011 and for 544 eligible hospitals (11 percent) for 2012.

Table 8 compares the likelihood of hospitals with specific characteristics having been awarded Medicare EHR incentive payments for 2012 compared to 2011. For this analysis, in contrast to that for tables 4 through 7, we calculated relative risk ratios that indicate how much more likely a hospital in a given category for 2012 was to have been awarded an EHR incentive payment than a hospital in the same category for 2011. For example, as table 8 shows, under the characteristic “geographic region,” the relative risk ratio of 3.8 for the category “Northeast” indicates that hospitals in the Northeast for 2012 were 3.8 times more likely to have been awarded an incentive payment than hospitals in the Northeast for 2011. A relative risk ratio of 1.0 would indicate that there was no difference between 2012 and 2011 in the likelihood of hospitals in that category having been awarded an incentive payment.

Overall, hospitals for 2012 were 3.0 times more likely to receive an incentive payment than hospitals for 2011. Therefore, for each category, a relative risk ratio greater than 3.0 indicates a greater increase than for hospitals overall in the likelihood of having been awarded an incentive payment for 2012 compared to 2011.

In examining the relationships presented in table 8, we found the following:

- The likelihood of hospitals having been awarded an incentive payment for 2012 compared to 2011 increased more in the Northeast and West than in the Midwest and South.
- Hospitals in rural areas were 3.1 times more likely to have been awarded an incentive payment for 2012 compared to 2011, which was a slightly greater increase than for hospitals overall.
- Critical access hospitals were 2.6 times more likely to have been awarded an incentive payment for 2012 compared to 2011, a moderately smaller increase than for hospitals overall.

Table 8: The Likelihood of Hospitals Being Awarded Medicare EHR Incentive Payments for 2012 Compared to 2011, by Characteristic

		Awarded a Medicare EHR incentive payment for 2011 (number (percentage))	Awarded a Medicare EHR incentive payment for 2012 (number (percentage))	Relative risk ratio ^a
Overall		777 (16.1)	2,291 (47.7)	3.0
Geographic region	Midwest	241 (16.5)	689 (47.4)	2.9
	Northeast	92 (15.2)	353 (58.1)	3.8
	South	353 (18.9)	900 (48.4)	2.6
	West	91 (10.2)	349 (39.4)	3.9
Location	Rural	282 (13.6)	882 (42.7)	3.1
	Urban	491 (18.0)	1,393 (51.3)	2.8
Hospital classification	Acute care hospital ^b	626 (17.9)	1,905 (54.9)	3.1
	Critical access hospital ^c	151 (11.3)	386 (28.9)	2.6
Ownership type	For-profit	174 (20.7)	415 (49.1)	2.4
	Government-owned	187 (15.3)	507 (42.9)	2.8
	Nonprofit	416 (15.2)	1,367 (49.5)	3.3
Chain membership	Chain	313 (20.2)	851 (51.7)	2.6
	Nonchain	454 (15.0)	1,419 (47.0)	3.1
Total beds ^d	Low	185 (11.5)	486 (30.3)	2.6
	Middle	265 (16.5)	827 (53.3)	3.2
	High	327 (20.3)	951 (59.4)	2.9

Source: GAO analysis of CMS, Office of the National Coordinator for Health Information Technology, and Health Resources and Services Administration data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the hospitals that were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible hospitals that were not awarded a payment in the same year. The sum of the number of hospitals listed by category may not equal the overall number of hospitals due to missing data.

^aThe relative risk ratios indicate how much more likely a hospital in a given category was to have been awarded an EHR incentive payment for 2012 than a hospital in the same category was to have been awarded an EHR incentive payment for 2011. A relative risk ratio of 1.0 would indicate that there was no difference in the likelihood of hospitals in that category having been awarded an incentive payment for 2012 compared to 2011.

^bAcute care hospitals are hospitals described in Section 1886(d) of the Social Security Act, which are paid under the inpatient prospective payment system.

^cCritical access hospitals typically are very small (25 inpatient beds or fewer) and operate in rural areas.

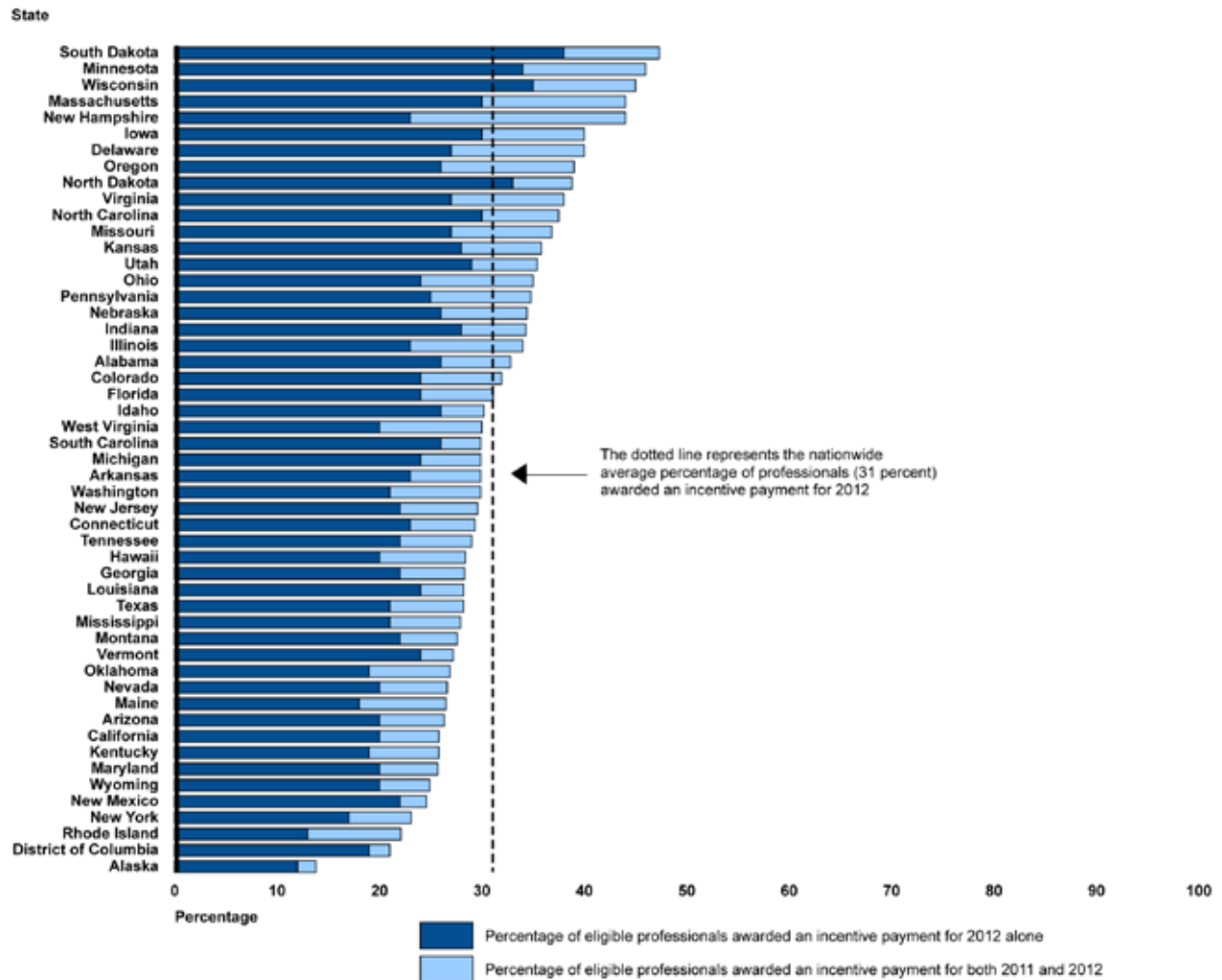
^dFor total beds, the ranges were as follows: for 2011, low—less than or equal to 38; middle—greater than 38 but less than or equal to 173; and high—greater than 173; and for 2012, low—less than or equal to 39; middle—greater than 39 but less than or equal to 174; and high—greater than 174.

**Information on Professionals Who Were Awarded Medicare
EHR Incentive Payments for 2012 and 2011**

This enclosure provides information on the amount of Medicare EHR incentive payments awarded to professionals for 2012, the number and percentage of professionals who were awarded incentive payments, and the characteristics of professionals who were awarded incentive payments. This enclosure also compares different categories of eligible professionals to determine which were more likely and which were less likely for 2012 to have been awarded an incentive payment. In some cases, information on Medicare EHR incentive payments awarded to professionals for 2011 is presented for comparison. In addition, this enclosure compares the characteristics of professionals awarded incentive payments for 2012 to the characteristics of professionals awarded incentive payments for 2011.

Of the estimated 588,156 eligible professionals, 31 percent or 183,712 professionals were awarded a Medicare EHR incentive payment for 2012. The percentage of eligible professionals who were awarded a Medicare EHR incentive payment varied by state for 2012. In contrast to hospitals, for which there were 18 states where 50 percent or more of eligible hospitals were awarded Medicare EHR incentive payments, for professionals there were no states with percentages over 50. Among states, South Dakota awarded Medicare EHR incentive payments to the greatest percentage of eligible professionals for 2012 at 47 percent, whereas 14 percent of eligible professionals in Alaska were awarded an incentive payment for 2012 (see fig. 6).

Figure 6: Percentage of Eligible Professionals Who Were Awarded a Medicare EHR Incentive Payment for 2012 Alone and for Both 2011 and 2012, by State



Source: GAO analysis of CMS data.

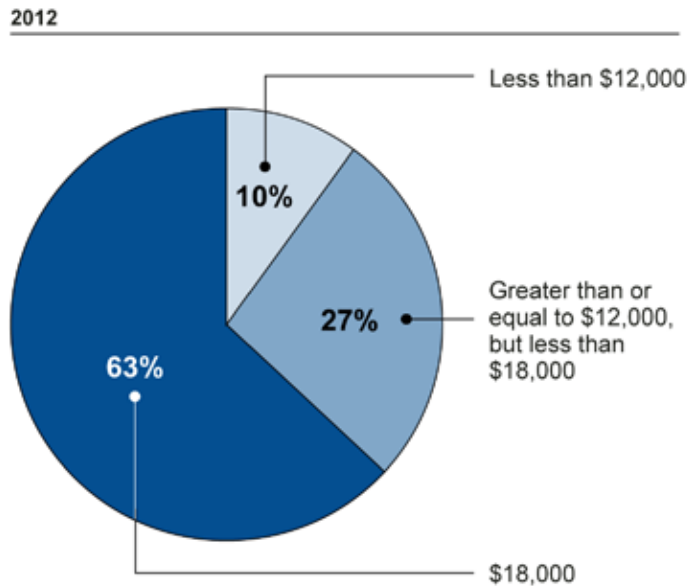
Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. This figure illustrates the percentage of eligible professionals who were awarded Medicare EHR incentive payments for 2012 by state, as indicated in the full length of each bar. These bars are divided to indicate the percentage of eligible professionals who were awarded an incentive payment only for 2012, designated by the darker shading, and the percentage of eligible professionals who were awarded an incentive payment for both 2011 and 2012, designated by the lighter shading. This figure excludes the 5,364 eligible professionals for 2011 (49 of which were awarded a Medicare EHR incentive payment) and the 5,093 eligible professionals for 2012 (259 of which were awarded a Medicare EHR incentive payment) who practiced in U.S. insular areas.

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Nationwide, most of the professionals (75 percent) who were awarded a Medicare EHR incentive payment for 2012 were new to the program—that is, they did not receive a payment for 2011—with substantial variation among states. These professionals make up 23 percent of eligible professionals nationwide. South Dakota had the largest percentage (38 percent) of eligible professionals who were new to the program for 2012, meaning they did not receive a payment for 2011. Additionally, almost all professionals who received Medicare EHR incentive payments for 2012 in the District of Columbia were new to the Medicare EHR incentive program for 2012. In contrast, approximately half of the professionals in New Hampshire who received incentive payments for 2012 were new to the program. While many professionals were new to the program for 2012, 20 percent of professionals awarded a Medicare EHR incentive payment for 2011 were not awarded a payment for 2012.

Of the \$6.3 billion in Medicare EHR incentive payments that were awarded to providers for 2012, \$2.8 billion was awarded to professionals. Among participating professionals, 63 percent were awarded an incentive payment of \$18,000, indicating these professionals first participated for 2012 and earned the maximum incentive payment amount. Twenty-seven percent were awarded an incentive payment of \$12,000 to less than \$18,000—85 percent of these professionals were first awarded incentives for 2011 and 15 percent were first awarded incentives for 2012 but earned less than the maximum incentive amount. Ten percent of professionals were awarded an incentive payment of less than \$12,000. (See fig. 7.)

Figure 7: Percentage of Professionals Who Were Awarded Medicare EHR Incentive Payments for 2012, by Amount



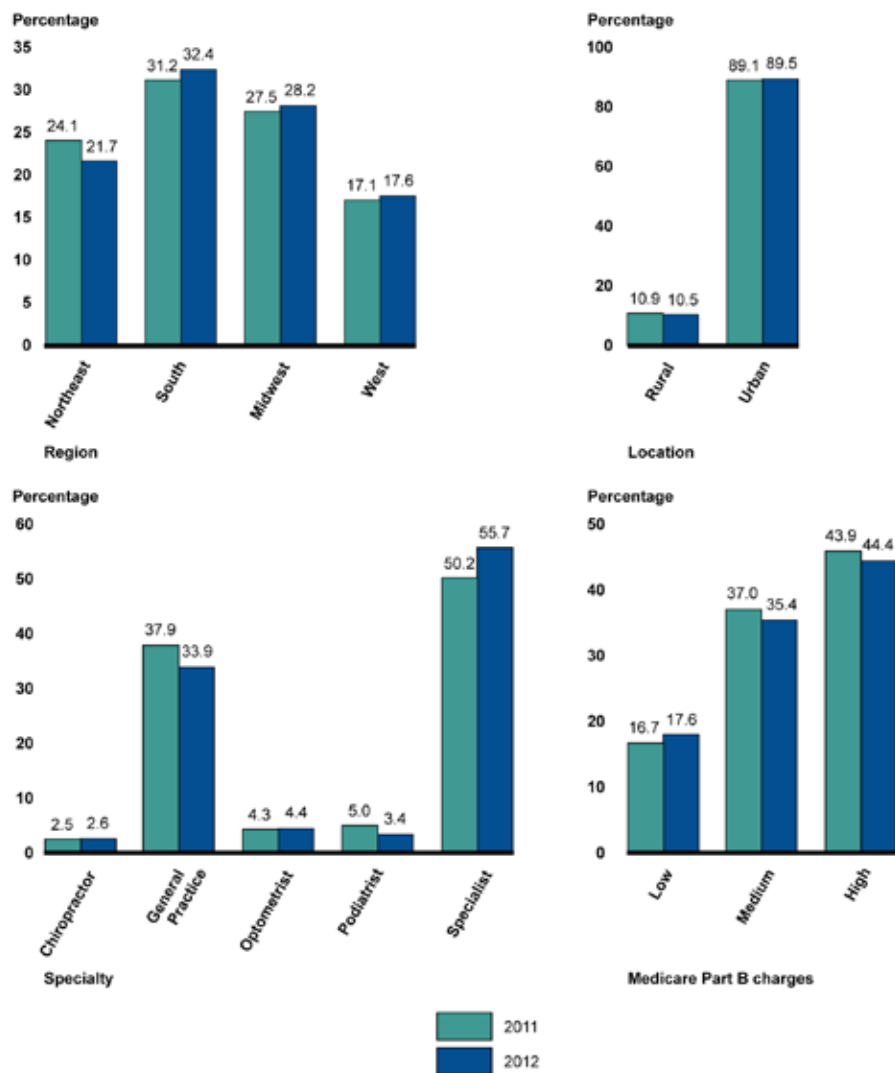
Source: GAO analysis of CMS data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. The figure does not include the 10 percent additional payments for professionals who practice predominately in a health professional shortage area because CMS had not disbursed those payments as of the date of our analysis. Therefore, the maximum payment amount professionals received for 2012 is \$18,000.

The characteristics among professionals who were awarded a Medicare EHR incentive payment for 2012 are similar to those among professionals awarded a Medicare EHR incentive payment for 2011 (see fig. 8). Specifically, for 2012,

- the largest proportion (32 percent) was in the South, and the smallest proportion (18 percent) was in the West;
- a significant majority (90 percent) was in urban areas;
- over half (56 percent) were specialty practice physicians, and over one-third (34 percent) were general practice physicians;
- about half (46 percent) had relatively high amounts of 2012 Medicare Part B charges.

Figure 8: Selected Characteristics of Professionals Who Were Awarded a Medicare EHR Incentive Payment for 2011 and 2012

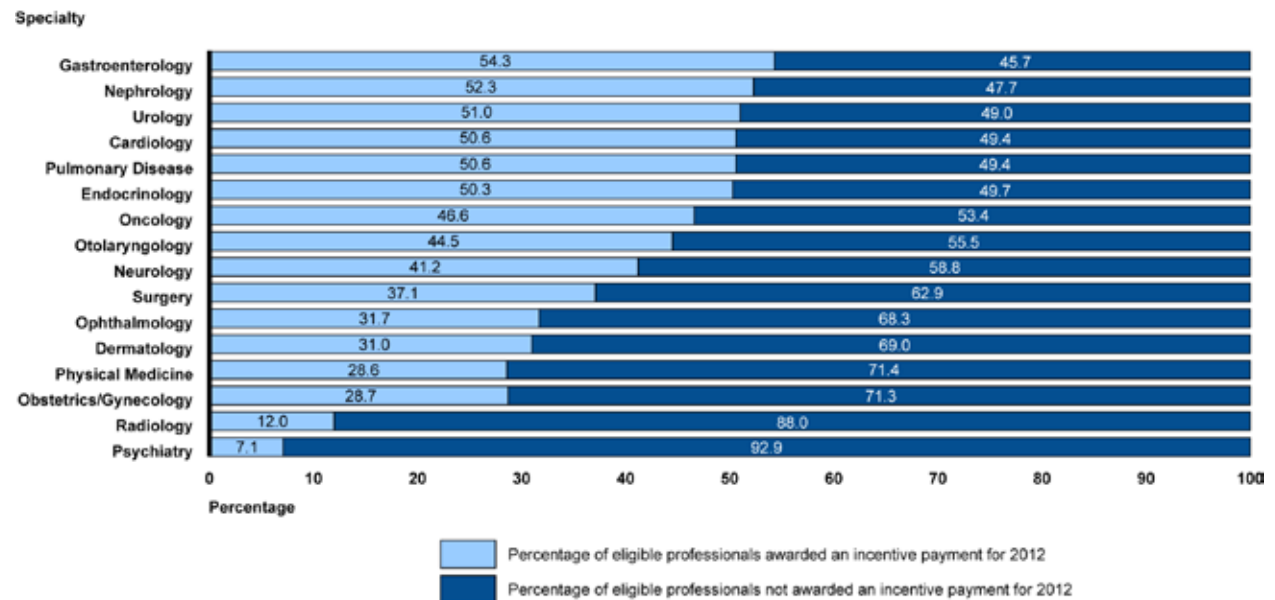


Source: GAO analysis of CMS and Health Resources and Services Administration data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. For a given year, the sum of the percentage of professionals listed for a given characteristic may not equal 100 percent due to missing data or rounding. For specialty, we did not include dentists because the percentages of dentists who were awarded a Medicare EHR incentive payment for 2011 and 2012 rounded to zero. This figure for region excludes the 5,364 eligible professionals for 2011 (49 of which were awarded a Medicare EHR incentive payment) and the 5,093 eligible professionals for 2012 (259 of which were awarded a Medicare EHR incentive payment) who practiced in U.S. insular areas. For Medicare Part B charges, the ranges were as follows: for 2011, low—less than or equal to \$29,747; middle—greater than \$29,747 but less than or equal to \$134,601; and high—greater than \$134,601; and for 2012, low—less than or equal to \$49,269; middle—greater than \$49,269 but less than or equal to \$218,365; and high—greater than \$218,365.

Specialists make up the largest proportion of professionals who were awarded a Medicare EHR incentive payment for 2012. However, a little less than one third (29 percent) of eligible specialty practice physicians were awarded a Medicare EHR incentive payment for 2012, and the percentage varied substantially by specialty. For example, 54 percent of gastroenterologists were awarded a Medicare EHR incentive payment, compared to 7 percent of psychiatrists. (See fig. 9.)

Figure 9: Percentage of Specialty Practice Physicians Who Were Awarded a Medicare EHR Incentive Payment for 2012, by Selected Specialty



Source: GAO analysis of CMS data.

Note: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013.

Tables 9 through 11 compare the characteristics of professionals who were awarded Medicare EHR incentive payments for 2012 and 2011 to those of other eligible Medicare professionals who did not receive a payment for those years. Each characteristic is divided into two or more categories. For example, the characteristic “geographic region” is divided into four categories—Midwest, Northeast, South, and West. As part of this analysis, we calculated relative risk ratios that indicate how much more likely a professional in each category was to have been awarded an EHR incentive payment in a given year than a professional in the category that was least likely to have been awarded a payment for the same year. The categories in which professionals were least likely to receive an incentive payment are labeled “–”. For example, as table 9 shows, under the characteristic “geographic region” for 2012, the relative risk ratio of 1.3 for the category “Midwest” indicates that, for 2012, professionals in the Midwest were 1.3 times more likely to have been awarded an incentive payment than professionals in the West, who were the least likely to receive an incentive payment. A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories for the given year, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

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Table 9 shows the relationship between professionals receiving Medicare EHR incentive payments for 2012 and the regions in which the professionals are practicing. We found that geographic location had a modest effect on the likelihood that professionals were awarded an EHR incentive payment for 2012. For example,

- professionals practicing in the Midwest—the region with the highest percentage of professionals awarded an incentive payment for 2012—were 1.3 times more likely to have been awarded a payment than professionals in the West—the region with the lowest percentage of professionals awarded an incentive payment in the same year;
- professionals practicing in health professional shortage areas were 1.3 times less likely to have been awarded a payment than other professionals; and
- in contrast, professionals practicing in urban areas were no more likely to have been awarded an incentive payment than rural professionals.

The relationship between geographic location and receiving a Medicare EHR incentive payment was generally similar for 2011 compared to for 2012.

Table 9: Number and Percentage of Professionals Who Were Awarded Medicare EHR Incentive Payments for 2011 and 2012, by Regional Characteristics

Characteristics	Categories	2011			2012		
		Number of eligible professionals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b	Number of eligible professionals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b
Overall		573,551	58,331 (10.2)	N/A	588,156	183,712 (31.2)	N/A
Geographic region ^c	Midwest	138,134	16,048 (11.6)	1.3	141,986	51,778 (36.5)	1.3
	Northeast	128,204	14,052 (11.0)	1.2	130,393	39,945 (30.6)	1.1
	South	190,443	18,215 (9.6)	1.1	195,729	59,464 (30.4)	1.1
	West	111,401	9,962 (8.9)	—	114,946	32,257 (28.1)	—
Location	Rural	62,380	6,332 (10.2)	—	62,486	19,194 (30.7)	—
	Urban	510,714	51,968 (10.2)	1.0	525,392	164,451 (31.3)	1.0
Located in a Health Professional Shortage Area	Yes	18,136	1,372 (7.6)	—	14,605	3,467 (23.7)	—
	No	554,968	56,930 (10.3)	1.4	573,295	180,184 (31.4)	1.3
Located in a county with a Beacon Community	Yes	36,848	3,196 (8.7)	—	37,299	11,916 (31.9)	1.0
	No	536,256	55,106 (10.3)	1.2	550,601	171,735 (31.2)	—

Source: GAO analysis of CMS, Office of the National Coordinator for Health Information Technology, and Health Resources and Services Administration data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the professionals who were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible professionals who were not awarded a payment in the same year. The sum of the number of professionals listed by category may not equal the overall number of professionals due to missing data.

^aWe use the term eligible professionals to refer to those professionals who were eligible for the Medicare EHR program, regardless of whether they were awarded a Medicare EHR incentive payment for 2011 and 2012. Specifically, eligible professionals are those who (1) were permissible types of providers: doctors of medicine, dental medicine or surgery, optometry, osteopathy, and podiatric medicine and chiropractors; (2) were not hospital-based; (3) had greater than \$0 in Medicare Part B charges in calendar year 2010 or 2011; (4) were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year; and (5) were not awarded an incentive payment from the Medicaid EHR program during the same year.

^bThe relative risk ratios indicate how much more likely a professional in each category was to have been awarded an EHR incentive payment than a professional in the category that was least likely to have been awarded a payment, which is labeled “—”. A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

^cFor 2011, 5,364 eligible professionals practiced in U.S. insular areas, which are not included in the four U.S. census regions. Of those, 49 (1 percent) were awarded a Medicare EHR incentive payment. For 2012, 5,093 eligible professionals practiced in U.S. insular areas, and 259 of them (5 percent) were awarded a Medicare EHR incentive payment.

Enclosure III

Table 10 shows the relationship between professional characteristics—such as specialty, years since the professional’s medical degree was awarded, and involvement with Regional Extension Centers—and receipt of a Medicare EHR incentive payment for 2012. We found that

- among general practice physicians and specialty practice physicians—the two specialty categories that together account for most of the eligible professionals—general practice physicians were 1.5 times more likely than specialty practice physicians to have been awarded a Medicare EHR incentive payment;¹
- professionals who signed an agreement to receive technical assistance from a Regional Extension Center were 1.9 times more likely to have been awarded a Medicare EHR incentive payment than professionals who did not; and
- professionals who were awarded their degrees less than 30 years ago were 1.3 times more likely to have been awarded a Medicare EHR incentive payment than professionals who were awarded their degrees 30 or more years ago.

Compared to specialty practice physicians, general practice physicians were even more likely for 2011 to have been awarded an incentive payment than they were for 2012.² Additionally, for 2011 the effect of having signed an agreement to receive technical assistance from a Regional Extension Center was greater than for 2012.

¹To determine how much more likely a general practice physician was to have been awarded a Medicare EHR incentive payment for 2012 than a specialty practice physician, we divided the probability that a general practice physician was awarded an incentive payment ($62,285/146,160 = 0.4261$) by the probability that a specialty practice physician was awarded an incentive payment ($102,328/349,004 = 0.2932$).

²For 2011, general practice physicians were 1.8 times more likely than specialty practice physicians to have been awarded a Medicare EHR incentive payment. To determine how much more likely a general practice physician was to have been awarded a Medicare EHR incentive payment for 2011 than a specialty practice physician, we divided the probability that a general practice physician was awarded an incentive payment ($22,094/142,223 = 0.1553$) by the probability that a specialty practice physician was awarded an incentive payment ($29,259/340,914 = 0.0858$).

Table 10: Number and Percentage of Professionals Who Were Awarded Medicare EHR Incentive Payments for 2011 and 2012, by Professional Characteristics

Characteristics	Categories	2011			2012		
		Number of eligible professionals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b	Number of eligible professionals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b
Overall		573,551	58,331 (10.2)	N/A	588,156	183,712 (31.2)	N/A
Professional specialty	General practice physician	142,223	22,094 (15.5)	23.2	146,160	62,285 (42.6)	28.1
	Specialty practice physician	340,914	29,259 (8.6)	12.8	349,004	102,328 (29.3)	19.3
	Chiropractor	45,076	1,443 (3.2)	4.8	45,836	4,688 (10.2)	6.7
	Dentist	3,442	23 (0.7)	—	3,363	51 (1.5)	—
	Optometrist	27,472	2,529 (9.2)	13.8	28,988	8,119 (28.0)	18.5
	Podiatrist	14,379	2,938 (20.4)	30.6	14,715	6,151 (41.8)	27.6
Signed an agreement to receive technical assistance from a Regional Extension Center	Yes	52,525	12,369 (23.5)	2.7	67,999	36,843 (54.2)	1.9
	No	521,026	45,962 (8.8)	—	520,157	146,869 (28.2)	—
Years since degree awarded	Low (15 years or fewer)	146,883	16,735 (11.4)	1.3	167,176	57,829 (34.6)	1.3
	Middle (16-29 years)	220,184	25,391 (11.5)	1.3	226,298	77,526 (34.3)	1.3
	High (30 years or more)	179,408	16,003 (8.9)	—	180,069	47,924 (26.6)	—

Source: GAO analysis of CMS and Office of the National Coordinator for Health Information Technology data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the professionals who were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible professionals who were not awarded a payment in the same year. The sum of the number of professionals listed by category may not equal the overall number of professionals due to missing data.

Enclosure III

^aWe use the term eligible professionals to refer to those professionals who were eligible for the Medicare EHR program, regardless of whether they were awarded a Medicare EHR incentive payment for 2011 and 2012. Specifically, eligible professionals are those who (1) were permissible types of providers: doctors of medicine, dental medicine or surgery, optometry, osteopathy, and podiatric medicine and chiropractors; (2) were not hospital-based; (3) had greater than \$0 in Medicare Part B charges in calendar year 2010 or 2011; (4) were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year; and (5) were not awarded an incentive payment from the Medicaid EHR program during the same year.

^bThe relative risk ratios indicate how much more likely a professional in each category was to have been awarded an EHR incentive payment than a professional in the category that was least likely to have been awarded a payment, which is labeled "--". A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

Enclosure III

Table 11 shows how much the size of professionals' practices under Medicare, measured in various ways, is related to whether professionals were awarded Medicare EHR incentive payments for 2012. We found that professionals who saw the largest number of Medicare patients and billed Medicare the largest amounts were the most likely to have been awarded a Medicare EHR incentive payment for 2012. Specifically,

- professionals with the highest total amount of Medicare Part B charges were 2.5 times more likely to have been awarded an incentive payment than professionals with the lowest amount of Medicare Part B charges; and
- professionals with the highest number of Medicare Part B encounters were 2.6 times more likely to have been awarded an incentive payment than professionals with the smallest number of encounters.

In contrast, the size of practices had a smaller effect on the likelihood that professionals were awarded incentive payments for 2012. For example, practices with 51 or more professionals were 1.4 times more likely to have been awarded an EHR incentive payment than solo practitioners.

The relationship between receiving a Medicare EHR incentive payment and the size of professionals' practices—measured using total amount of Medicare Part B charges, total number of Medicare Part B encounters, and number of professionals—was generally similar for both years; however, the magnitudes of the differences were smaller for 2012.

Table 11: Number and Percentage of Professionals Who Were Awarded Medicare EHR Incentive Payments for 2011 and 2012, by Practice Size

Characteristics	Categories	2011			2012		
		Number of eligible professionals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b	Number of eligible professionals ^a	Number (percentage) awarded a Medicare EHR incentive payment	Relative risk ratio ^b
Overall		573,551	58,331 (10.2)	N/A	588,156	183,712 (31.2)	N/A
Total amount of Medicare Part B charges (dollars) ^c	Low	190,527	9,742 (5.1)	—	194,249	32,281 (16.6)	—
	Middle	191,098	21,583 (11.3)	2.2	194,832	64,955 (33.3)	2.0
	High	190,527	25,607 (13.4)	2.6	194,249	81,650 (42.0)	2.5
Total number of Medicare Part B encounters ^d	Low	190,636	8,934 (4.7)	—	194,422	31,376 (16.1)	—
	Middle	190,960	19,940 (10.4)	2.2	194,627	66,550 (34.2)	2.1
	High	190,556	28,058 (14.7)	3.1	194,281	80,960 (41.7)	2.6
Number of professionals in practice	Solo practice	54,148	4,354 (8.0)	—	181,140	54,947 (30.3)	—
	2-10 professionals	99,245	12,535 (12.6)	1.6	67,704	25,373 (37.5)	1.2
	11-50 professionals	67,182	7,354 (10.9)	1.4	38,520	13,946 (36.2)	1.2
	51 or more professionals	144,709	18,470 (12.8)	1.6	70,282	30,077 (42.8)	1.4
	More than one group practice of different sizes	122,812	12,202 (9.9)	1.2	155,333	51,051 (32.9)	1.1
	Missing ^e	85,455	3,416 (4.0)	—	75,177	8,318 (11.1)	—

Source: GAO analysis of CMS data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the professionals who were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible professionals who were not awarded a payment in the same year. The sum of the number of professionals listed by category may not equal the overall number of professionals due to missing data.

^aWe use the term eligible professionals to refer to those professionals who were eligible for the Medicare EHR program, regardless of whether they were awarded a Medicare EHR incentive payment for 2011 and 2012. Specifically, eligible professionals are those who (1) were permissible types of providers: doctors of medicine, dental medicine or surgery, optometry, osteopathy, and podiatric medicine and chiropractors; (2) were not hospital-based; (3) had greater than \$0 in Medicare Part B charges in calendar year 2010 or 2011; (4) were not awarded an incentive payment from the Medicare Advantage Organization (MAO) EHR program during the same year; and (5) were not awarded an incentive payment from the Medicaid EHR program during the same year.

^bThe relative risk ratios indicate how much more likely a professional in each category was to have been awarded an EHR incentive payment than a professional in the category that was least likely to have been awarded a payment, which is labeled “—”. A relative risk ratio of 1.0 indicates no difference in the likelihood of having been awarded an incentive payment between the two categories, and, as relative risk ratios approach 1.0, there is less and less difference in the likelihood of having been awarded an incentive payment between the two categories.

^cFor total amount of Medicare Part B charges, the ranges were as follows: for 2011, low—less than or equal to \$29,747; middle—greater than \$29,747 but less than or equal to \$134,601; and high—greater than \$134,601; and for 2012, low—less than or equal to \$49,269; middle—greater than \$49,269 but less than or equal to \$218,365; and high—greater than \$218,365.

Enclosure III

^dFor total amount of Medicare Part B encounters, the ranges were as follows: for 2011, low—less than or equal to 664; middle—greater than 664 but less than or equal to 2,781; and high—greater than 2,781; and for 2012, low—less than or equal to 682; middle—greater than 682 but less than or equal to 2,561; and high—greater than 2,561.

^eOur analysis of the number of professionals in eligible professionals' practices includes only a subset of professionals. That is, information on the number of professionals in the practice was missing for 85,455 professionals (15 percent) for 2011 and 75,177 professionals (13 percent) for 2012.

Enclosure III

Table 12 compares the likelihood of professionals with specific characteristics having been awarded Medicare EHR incentive payments for 2012 compared to 2011. For this analysis, in contrast to that for tables 9 through 11, we calculated relative risk ratios that indicate how much more likely a professional in a given category for 2012 was to have been awarded an EHR incentive payment than a professional in the same category for 2011. For example, as table 12 shows, under the characteristic “geographic region” for 2011, the relative risk ratio of 2.8 for the category “Northeast” indicates that professionals in the Northeast for 2012 were 2.8 times more likely to have been awarded an incentive payment than professionals in the Northeast for 2011. A relative risk ratio of 1.0 would indicate that there was no difference between 2012 and 2011 in the likelihood of professionals in that category having been awarded an incentive payment.

Overall, professionals for 2012 were 3.1 times more likely to receive an incentive payment than professionals for 2011. Therefore, for each category, a relative risk ratio greater than 3.1 indicates a greater increase than for professionals overall in the likelihood of having been awarded an incentive payment for 2012 compared to 2011.

In examining the relationships presented in table 12, we found the following:

- The likelihood of general practice physicians, dentists, and podiatrists having been awarded an incentive payment for 2012 compared to 2011 increased less than the likelihood of specialty practice physicians, chiropractors, optometrists, and professionals overall.
- Professionals who signed an agreement to receive technical assistance from a Regional Extension Center were 2.3 times more likely to have been awarded an incentive payment for 2012 compared to 2011, a much smaller increase than for professionals who did not sign an agreement and for professionals overall.
- Professionals with the lowest total amount of Medicare Part B charges were 3.3 times more likely to have been awarded an incentive payment for 2012 compared to 2011, which was a slightly greater increase than for professionals with more Medicare Part B charges. While professionals with more charges were still more likely to have received incentive payments than professionals with fewer charges, these data indicate a narrowing of the gap between groups.

Table 12: The Likelihood of Professionals Being Awarded Medicare EHR Incentive Payments for 2012 Compared to 2011, by Characteristic

		Awarded a Medicare EHR incentive payment for 2011 (number (percentage))	Awarded a Medicare EHR incentive payment for 2012 (number (percentage))	Relative risk ratio ^a
Overall		58,331 (10.2)	183,712 (31.2)	3.1
Geographic region	Midwest	16,048 (11.6)	51,778 (36.5)	3.1
	Northeast	14,052 (11.0)	39,945 (30.6)	2.8
	South	18,215 (9.6)	59,464 (30.4)	3.2
	West	9,962 (8.9)	32,257 (28.1)	3.1
Location	Rural	6,332 (10.2)	19,194 (30.7)	3.0
	Urban	51,968 (10.2)	164,451 (31.3)	3.1
Professional specialty	General practice physician	22,094 (15.5)	62,285 (42.6)	2.7
	Specialty practice physician	29,259 (8.6)	102,328 (29.3)	3.4
	Chiropractor	1,443 (3.2)	4,688 (10.2)	3.2
	Dentist	23 (0.7)	51 (1.5)	2.3
	Optometrist	2,529 (9.2)	8,119 (28.0)	3.0
	Podiatrist	2,938 (20.4)	6,151 (41.8)	2.0
Signed an agreement to receive technical assistance from a Regional Extension Center	Yes	12,369 (23.5)	36,843 (54.2)	2.3
	No	45,962 (8.8)	146,869 (28.2)	3.2
Total amount of Medicare Part B charges (dollars) ^b	Low	9,742 (5.1)	32,281 (16.6)	3.3
	Middle	21,583 (11.3)	64,955 (33.3)	3.0
	High	25,607 (13.4)	81,650 (42.0)	3.1
Number of professionals in practice ^c	Solo practice	4,354 (8.0)	54,947 (30.3)	3.8
	2-10 professionals	12,535 (12.6)	25,373 (37.5)	3.0
	11-50 professionals	7,354 (10.9)	13,946 (36.2)	3.3
	51 or more professionals	18,470 (12.8)	30,077 (42.8)	3.4
	More than one group practice of different sizes	12,202 (9.9)	51,051 (32.9)	3.3

Source: GAO analysis of CMS, Office of the National Coordinator for Health Information Technology, and Health Resources and Services Administration data.

Notes: We analyzed data CMS collects pertaining to the Medicare EHR program through July 2, 2013. We compared the characteristics of the professionals who were awarded a Medicare EHR incentive payment for 2012 and for 2011 to those of other eligible professionals who were not awarded a payment in the same year. The sum of the number of professionals listed by category may not equal the overall number of professionals due to missing data.

^aThe relative risk ratios indicate how much more likely a professional in a given category was to have been awarded an EHR incentive payment for 2012 than a professional in the same category was to have been awarded an EHR incentive payment for 2011. A relative risk ratio of 1.0 would indicate that there was no difference in the likelihood of professionals in that category having been awarded an incentive payment for 2012 compared to 2011.

^bFor total amount of Medicare Part B charges, the ranges were as follows: for 2011, low—less than or equal to \$29,747; middle—greater than \$29,747 but less than or equal to \$134,601; and high—greater than \$134,601; and for 2012, low—less than or equal to \$49,269; middle—greater than \$49,269 but less than or equal to \$218,365; and high—greater than \$218,365.

^cInformation on the number of professionals in the practice was missing for 85,455 professionals (15 percent) for 2011 and 75,177 professionals (13 percent) for 2012.

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