APPENDIX D. INELIGIBLE PROVIDER CHARACTERISTICS

This appendix provides data on ineligible health care providers to understand the size of the market, number of patients' served, expenditures for Medicare and Medicaid and other information. Comparability from one setting to the next was not always possible due to the number of diverse sources needed to produce the statistical data,[1] overlapping services between health care providers, and lack of standardization across provider classifications at the federal and state levels. Please note, those expenditures in this table based on claims data generally exclude Medicare and Medicaid managed care. The assumptions made are documented in the footnotes.

Congress wanted to understand the extent to which ineligible providers work in settings that might receive EHR incentives or other funding under HITECH. Findings are documented in the "ownership" column, however data was very limited. MedPAC or the American Hospital Association survey provided the best sources of data indicating the percentage of hospitals with specialty units or services that included the ineligible provider types. There was limited to no information available for the number or percentage of the ineligible professionals/practitioners who work for eligible providers. Some eligible professionals may work in multiple types of provider settings, including settings ineligible for incentives. These providers may choose to retain their incentive payment, or assign the payment to a setting where they work. For example, physicians may assign incentive payment to their primary practice and not to the rural health clinic, ambulatory surgical center, or nursing home where they also practice. We were not able to find a source that tracked assignment of incentives.

[1] For a full list of data resources used, see the Sources section at the end of this appendix.

Ineligible Provider	No. of Providers	No. of Patients/ Individuals Served	Medicare Expenditures[1]	Medicaid Expenditures	Total Health Care Expenditures	Profitability/ Profit Margin[2]	Ownership[3]
Long-Term and Post-Acute Care							
Nursing Homes (SNF/NF)	15,716[4]	1,385,955[5]	$31.9B[6]	$50B[7]	$143.1B[8]	18.5% for SNFs	60% chain-owned 93.6% freestanding 24% of the approximately 4800 hospitals surveyed by American Hospital Association (AHA) have skilled nursing care units
Inpatient Rehabilitation Facilities (IRFs)	1,179[11]	397,256[12]	$6.32B[13]	N/A[14]	$11.0B[15]	8.8%[16]	80% hospital-based; 20% freestanding[17] 29.3% of the approximately 4800 hospitals surveyed by AHA have inpatient physical rehabilitation units.
Long-Term Care Hospitals (LTCHs)	436	118,300	$5.2B	$520M	S8.0B	6.4% overall 6.7% urban facilities -0.5% rural 5.6% free-standing 8.1% HwH -0.6% nonprofit; 7.2% for profit	62% are freestanding (38% hospital within hospital) Over 60% of LTCHs are co-located with acute care hospitals, but under separate ownership Approximately 7% of almost 4800 hospitals surveyed by the AHA report having a LTCH unit.

Ineligible Provider	No. of Providers	No. of Patients/ Individuals Served	Medicare Expenditures[1]	Medicaid Expenditures	Total Health Care Expenditures	Profitability/ Profit Margin[2]	Ownership[3]
Home Health Agencies (HHAs)[25]	12,026[26]	3,400,000[27]	$19.6B[28]	$4.8B[29]	$44.7B[30]	In 2010, HHA margins in aggregate were 19.4% for freestanding agencies[31]	90% freestanding[32] 69.7% proprietary 69.5% not part of a chain 81.6% Medicare-certified 80.7% Medicaid-certified[33] 27% of the approximately 4800 hospitals surveyed by AHA offer home health services
Hospice Agencies	5,150[34]	1,580,000[35]	$13.0B	$2.36B[36]	$17.1B[37]	5.1%[38]	58% freestanding 19.2% home health based 21.3% hospital based 1.4% SNF-based[39] 76.3% not part of a chain 93.4% Medicare-certified 86.4% Medicaid-certified[40] 20.7% of the approximately 4,800 hospitals surveyed by AHA offer hospice services
Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/IID)[41]	6514[42]	87,560[43]	$0[44]	$13.62B[45]	$18.3B[46]		87% private 13% public[47] 95% operated by nonstate agencies [67% of large (<16 residents), 95% (7-15 residents) and 99% (6 or fewer)]

Ineligible Provider	No. of Providers	No. of Patients/ Individuals Served	Medicare Expenditures[1]	Medicaid Expenditures	Total Health Care Expenditures	Profitability/ Profit Margin[2]	Ownership[3]
Behavioral Health							
Psychiatric Hospitals/Units including Substance Abuse Treatment	2497 1749 (MH)[48] 748 (SA)[49]	1,909,238 1,894,000 (MH)[50] 15,238 (SA)[51]	$4.3B (MH)[52] Substance abuse--see note[53]	$2.96B $2.5B (MH)[54] $46M (SA)[55]	$23.06B $20.18B (MH) $2.88B (SA)[56]	See note.[57]	72% of psychiatric inpatient facilities are hospital-based units 28% are freestanding The largest psychiatric hospital chain owns 102 of the 300 freestanding psychiatric hospitals[58] 87% of inpatient substance abuse facilities are private 13% government 33.6% of the approximately 4,800 hospitals surveyed by AHA report having inpatient psychiatric units 9.7% offer substance abuse treatment
Residential Treatment Centers (RTCs) (Mental Health and/or Substance Abuse)	4492[60]	314,393[61]	See note.[62]	$2.03B[63]	S21.77B[64]		
Community Mental Health Centers	1400[65]	6.0M[66]	$218.6M[67]	$15.8B[68]	$26.8B[69]		

Ineligible Provider	No. of Providers	No. of Patients/ Individuals Served	Medicare Expenditures[1]	Medicaid Expenditures	Total Health Care Expenditures	Profitability/ Profit Margin[2]	Ownership[3]
Clinical Psychologists	93,960[70]	Private office: 7,648,000 (aged 18 and older) (includes psychiatrists) Private office: 2,281,000 (children 12-17) (includes psychiatrists) 2,276,000 (aged 12-17) (school social worker, psychologist, or counselor)[71]	$387M[72]	$951M[73]	$6.45B[74]	N/A	See note.[75]
Clinical Social Workers	249,280[76]				$10B[77]	N/A	See note.[78]
Safety Net Providers							
Federally Qualified Health Centers (FQHC)	1,124[79]	19,469,467[80]	$674M[81]	$4.25B[82]	$11.5[83]		All FQHCs are freestanding
Rural Health Centers (RHC)	3950[84]	6.5M[85]	$312M	$800M[86]	1.9B[87]	Most operate at a deficit[88]	52% independent; 48% provider-based[89]
Other Health Care Providers							
Ambulatory Surgical Centers (ASC)	5976[90]	14.9M[91]	$3.5B[92]	612M[93]	$12.3B[94]	See note[95]	65% physician-owned 17% hospital/ physician-owned 20% corporate (including physician and physician-hospital) 2% hospital-owned[96] 22% owned by major multi-facility chains[97] 24.5% of hospitals replying to the 2010 AHA survey have ambulatory surgery centers
Renal Dialysis Facilities	5,760[98]	571,000[99]	$29.1B[100]	$13.5B[101]	$42.6B	2.3%[102]	60% of dialysis facilities in the United States are owned by two for-profit chains[103] 90% freestanding 10% hospital-based[104]

Ineligible Provider	No. of Providers	No. of Patients/ Individuals Served	Medicare Expenditures[1]	Medicaid Expenditures	Total Health Care Expenditures	Profitability/ Profit Margin[2]	Ownership[3]
Emergency Medical Service Providers	19,971[105]	36.7M events 28M transports	$5.5B[106]	$2.1B[107]	$16.7B[108]	2%[109]	9% hospital-affiliated 37% fire department-affiliated 21% affiliated with another government agency 33% freestanding, for-profit or not-for-profit[110]
Pharmacies	62,892	3.75B prescriptions	$63.53B prescription drugs	$15.85B prescription drugs	$259.1B prescription drugs		60% chain 36% independent/ private 2% government 2% other (franchise, HMO, university/school) Typical Settings: 60% pharmacies and drug store 26% grocery or department store 10% hospital 4% other (medical or walk-in clinic, university/ school, nursing home, or corporate)[115]
Pharmacists	274,900 (249,391 in 2009)[116]						Typical Provider Setting: 43% pharmacies and drug stores 23% hospitals 14% grocery or department stores 5% other general merchandise stores[117]
Laboratories	232,996[118]		$8.9B[119]	$1.56B[120]	$61B[121]		1995 data: 55% Hospital-based 37% Independent clinical laboratories 8% Physician office Independent clinical laboratories were the fastest growing segment of the market[122]
Blood Centers	2628[123]	15,014,000[124]	See note[125]				See note[126]

Ineligible Provider	No. of Providers	No. of Patients/ Individuals Served	Medicare Expenditures[1]	Medicaid Expenditures	Total Health Care Expenditures	Profitability/ Profit Margin[2]	Ownership[3]
Physical/ Occupational/ Speech Language Therapists	393,110[127]		$3.83M[128]	$742M[129]	$28.3B[130]		See note[131]
Registered Dietitians/ Nutritional Professionals	53,510[132]		See note[133]		$3.42B[134]		See note[135]

Table Notes

1. Medicare expenditures (unless otherwise noted) are from the MedPAC June 2012 data book. MedPAC estimates are generally based on fee-for-service patients, and exclude the approximately 25% of Medicare enrollees now in managed care.
2. Profit margin information (unless otherwise noted) is based on the most recent MedPAC analysis of Medicare-certified facilities.
3. This column reflects provider ownership or affiliation to the extent the information was available. Data may not be comparable across the various provider types. AHA data on hospital-based specialty units is from AHA (*AHA Hospital Statistics, 2012 Edition*).
4. November 2011 data. Most facilities are dually-certified as Medicaid nursing facilities (NFs) and Medicare-certified skilled nursing facilities (SNFs). As of November 2011, of 15,716 total, 14,344 (91%) were dually certified; 788 (5%) were SNF only, and 594 (4%) were NF only (CMS. Compendium 2011). According to MedPAC, 15,161 NFs were Medicare-certified SNFs in 2011. AHCA statistics, based on CMS-CASPAR data as of June 2012, show a slight decrease in the number of nursing home providers--15,673. (AHCA, LTC Stats: Nursing Facility, 2012)
5. American Health Care Association (AHCA) using CMS-CASPAR data as of June 2012. (American Health Care Association. Research Department. *LTC Stats: Nursing Facility Patient Characteristics Report, June 2012 update*. http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/LTC%20STATS_HSNF_PATIENT_2012Q2_FINAL.pdf).
6. 2011 data (MedPAC, June 2012).
7. 2010 data (MedPAC, March 2012). Spending on nursing home care varies substantially depending on source. National Health Expenditure Accounts put the figure for 2010 at $45.1B. Eiken et al. indicate Medicaid expenditures for nursing homes in 2009 was $51.3B. Kaiser's estimates the total for 2010 to have been $50.5B, based on analysis of CMS (Form 64) data.
8. CMS, National Health Expenditures 2010.
9. 2010 data (MedPAC, June 2012). A 2011 Government Accountability Office (GAO) report showed margins much lower than MedPAC's analysis, but also recognized wide variation between private investment facilities and other for-profit and nonprofit facilities. GAO likely was looking at all NFs, while MedPAC focuses on Medicare-certified SNFs. The GAO report noted there was also wide variation based on other factors, stating: "On average, facility margins were also higher (1) the greater the percentage of residents whose stay was paid by Medicare, (2) the greater the number of beds, (3) the greater the occupancy rate, and (4) the lesser the degree of competition in the county." (GAO, 2011)
10. Grabowski, 2010.
11. 2010 data. (MedPAC, March 2012)
12. Ibid 2010 data. (MedPAC, March 2012)
13. 2010 data. (MedPAC, June 2012)
14. Provision of rehabilitation services is optional for state Medicaid agencies, although covered by most states. CMS puts Medicaid expenditures for rehabilitation services at $7.3 billion (Medicare and Medicaid Statistical Supplement, 2011). It is not clear what it covers and whether it includes inpatient. An analysis of IRFs in Pennsylvania estimated that, while approximately 52% of net patient revenues came from Medicare, about 8.6% of revenues were from patients receiving medical assistance. It was noted that, while Medicare covers the majority of patients served in Pennsylvania rehabilitation facilities, younger, Medicaid patients tended to have a longer length of stay. (Pennsylvania Health Care Cost Containment Council, November 2008)
15. Based on MedPAC's estimation that Medicare pays about 60%.
16. Profit margins vary greatly from one IRF to another depending upon geography (urban/rural), ownership (nonprofit, for-profit, government), freestanding or hospital-based, and number of beds. (MedPAC, March 2012)
17. 2010 data. One major freestanding IRF chain accounted for almost 50% of freestanding IRF revenues, and hospital-based units accounted for almost 60% of Medicare payments to IRFs in 2010. (MedPAC, March 2012)
18. 2011 data (MedPAC, June 2012).

19. 2010 data (MedPAC. March 2012).
20. 2010 data (MedPAC, June 2012).
21. According to the Dartmouth-Hitchcock health care system, long-term acute care is a Medicare-designated level of acute care services, although Medicaid will pay for care in these facilities as long as it is a state-contracted Medicaid provider. (Dartmouth-Hitchcock, Long-Term Acute Care, http://patients.dartmouth-hitchcock.org/care_mgt/long_term_acute_care.html). Medicare is the predominant payer accounting for roughly two-thirds of LTCH patients (MedPAC, March 2012). MedPAC estimates Medicaid patient share at between 5% and 8%. (MedPAC, June 2012)
22. Based on MedPAC's estimation that Medicare pays for about two-thirds of LTCH costs.
23. Grabowski, 2010. In 2011, two major chains owned just over half of all LTCHs. Both major chains operate IRFs and outpatient rehabilitation clinics in addition to LTCHs. The share of discharges from freestanding facilities in 2010 was 70%. (MedPAC, March 2012)
24. CMS. Determining Medical Necessity and Appropriateness of Care for Medicare Long Term Care Hospitals, 2011.
25. Home health expenditures vary greatly from one data source to another. The discrepancies appear to arise both from Medicaid dollars going to Home and Community-Based Services (HCBS), Home and Community-Based Waivers (HCBW), Program of All-Inclusive Care for the Elderly (PACE), personal services, etc. (cf. CMS MBES data, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/CMS-64-Quarterly-Expense-Report.html), and the inclusion in some estimations of providers not providing medical services. The National Association for Home Care and Hospice (NAHC), e.g. includes HHAs, hospices, as well as private duty and home care aide agencies, both Medicare certified, Medicaid approved, and private in their estimation of the number of home health providers (e-mail correspondence, Mary St. Pierre, NAHC, September 28, 2012).
26. Medicare-certified agencies. 2011 data. MedPAC (June 2012). The National Home and Hospice Care Survey estimated 33,000 HHAs 2010, including Medicare certified HHAs, Medicare certified hospices, and an estimation of non-Medicare agencies. We chose not to use the NAHC estimate, based on concerns the number included entities not providing medical services.
27. 2010 data (MedPAC, March 2012). NAHC estimates there were 7.6M recipients of home care services in 2007, a number cited by the National Center for Health Statistics in their survey of HHAs and hospices (Caffrey et al., 2011). NCHS does not provide an estimate of total home health patients but states on any given day in 2007, there were 1.46 million current home health care patients in the United States (CDC, Home Health Care Patients, n.d.). NAHC's estimate for 2010, which includes in-home hospice, was 12 million. (NAHC, 2010)
28. 2011 data (MedPac, June 2012). U.S. Census Bureau estimates of home health care services revenues from Medicare (2010) are $27.4B and from Medicaid $13.5B, with total patient revenues at $65B. (Census Bureau, 2010 Service Annual Survey)
29. CMS states Medicaid expenditures for "home health and related" service for 2010 were $54 billion, breaking it down by home health ($4,751 million), HCBW ($36,161 million), and personal care services ($13,170 million) (Data Compendium, 2011). CMS' National Health Expenditures Accounts puts the total Medicaid expenditure at $26.2 billion, of which $17.2 billion is the federal portion and $9 billion state and local. NHEA numbers cover a wide range of home health services, not limited to that provided by HHAs.
30. Based on MedPAC estimates that Medicare pays for 45% of home health services. NHEA puts total expenditures at $70.2 billion ($31.5 billion Medicare, $26.2 billion Medicaid, $5 billion out-of-pocket, $4.5 billion private insurance, $0.8 billion Veteran's Administration, $2.2 billion other third party payers/programs). NHEA home care expenditures include any service provided in a patient's home, likely extending beyond that provided by HHAs. (CMS. NHEA, 2011)
31. MedPAC (March 2012). http://www.medpac.gov/chapters/Mar12_Ch08.pdf.
32. MedPAC (March 2012).
33. 2007 data. (Park-Lee, 2010)
34. 2010 data (NHPCO, 2012). CMS indicates 3552 hospice agencies filed claims with Medicare in 2010 (CMS, Final Rule 76 FR 47327, August 2011).
35. 2010 data. (NHPCO, 2012)
36. "CMS Benefit Payments by Major Program Service Categories, fiscal year 2010" (CMS Compendium, December 2011).
37. Based on NAHC's estimate that Medicare and Medicaid pay about 90% of hospice claims. (NAHC, 2010)
38. Profit margins range between -13% and 13% dependent on geography and ownership.
39. Grabowski, 2010.
40. 2007 data. (Park-Lee, 2010)
41. ICFMR is the statutory term. These facilities are now widely referred to as ICF/IIDs including in the CMS Conditions of Participation, therefore we are using ICF/IID to represent the statutorily defined ICFMR.
42. 2010 data (Larson et al., 2012). The AHCA counts 6465 ICFMRs, based on CMS CASPER/OSCAR data as of October 2011. (AHCA, LTC Stats: ICF/MR/DD, 2011)
43. 2010 data (Larson et al., 2012). The Coleman Institute puts the number of persons in ICFMRs (2009) at 62,311 (20,768 (≤6 persons); 41,543 (7 or more persons)) but residents in state facilities appear to be counted separately (Braddock et al., I/DD Spending by Revenue Source, 2011). AHCA indicates the total number of clients in ICFs in October 2011 was 87,400, with 55,950 in private facilities and 31,450 in public facilities. (AHCA LTC Stats: ICF/MR/DD, 2011). CMS-64 data for 2009 counts 100,723 unique beneficiaries with 5.1 million total ICF claims at a cost to Medicaid of $12.9B (CMS, Financial Management Report). The Social Security Administration put the 2009 number at 101,000. "Table 8.E1--Number of recipients, total vendor payments, and average payment, by type of medical service, fiscal years 1985-2009" (U.S. Social Security Administration, 2011, http://www.ssa.gov/policy/docs/statcomps/supplement/2011/8e.html#table8.e1). AHCA counts 87,400 total ICFMR clients as of October 2011. The

CMS website indicates approximately 129,000 residents of ICFs are Medicaid-funded. According to Braddock (Braddock, Challenges, 2011) and AHCA (Eljay, LLC, 2011), numbers of institutionalized residents with intellectual and developmental disabilities are decreasing largely due to HCBW. The Coleman Institute states that, in 2009, 32,469 residents with intellectual or developmental disabilities were living in nursing facilities. (Braddock et al., *The State of the States*, 2011)

44. Medicare does not cover the types of custodial services ICFs provide.
45. The Henry J. Kaiser Family Foundation. "Distribution of Medicaid Spending on Long Term Care, FY2010" (Kaiser, Statehealthfacts.org, http://www.statehealthfacts.org/comparetable.jsp?ind=180&cat=4). Larson et al. indicate total Medicaid federal and state expenditures for ICFMR services in FY 2009 was $12.87B. Braddock estimated Medicaid spending for ICFMR facilities in 2009 to be just under $16B (Braddock, 2011). Americans with developmental disabilities and mental retardation make up approximately 1.3% of Medicaid recipients, but account for about 9.3% of Medicaid payouts. Medicaid is the primary source of funding, but other funds are available. (Highbeam Business, 2012).
46. This amount is for total receipts in 2007. (Census Bureau, 2007)
47. 2010 data. Public facilities housed 38% of clients and private facilities housed 62%, suggesting that public ICFs had a higher bed capacity. (AHCA, State Long-Term Health Care Sector, 2011)
48. Includes nongovernment inpatient psychiatric hospitals (255), hospital psychiatric units (1274), state psychiatric hospitals (220) (Dobson, 2010). Avalere, in their analysis of the costs of extending EHR incentive payments to behavioral health providers, estimated 360 psychiatric hospitals, based on the number filing Medicare reports (Avalere, 2010). MedPAC counts 1536 (426 freestanding and 1100 hospital-based), a number that probably excludes state psychiatric hospitals. SAMHSA's database of mental health hospital inpatient facilities includes 1608 facilities where hospital inpatient services are available. (SAMHSA. Mental Health Treatment Facility Locator)
49. N-SSATS data as of March 31, 2010 (http://www.samhsa.gov/data/DASIS/2k10nssats/NSSATS2010Tbl4.2a.htm) SAMHSA's online database of substance abuse facilities includes 588 that are hospital inpatient. (SAMHSA, data set created May 23, 2011; updated June 30, 2012.) SAMHSA's 2008 National Survey of Substance Abuse Treatment Services specified 838 substance abuse treatment facilities were hospital inpatient, with 317 having a primary focus of substance abuse, 296 focusing on a mix of substance abuse and mental health, 161 focusing on mental health care, and the rest focusing on general health care or other.
50. "Number and percentage of persons aged 18 or older who received mental health treatment in the past year, by disorder severity, United States, 2009" (Table 24, SAMHSA, Mental Health, U.S. 2010). MedPAC counts 431,276 Medicare patients. (MedPAC, June 2012)
51. N-SSATS data as of March 31, 2010 (http://www.samhsa.gov/data/DASIS/2k10nssats/NSSATS2010Tbl5.2a.htm).
52. 2011 data. (MedPAC)
53. There is no Medicare inpatient substance abuse treatment provider type. A very broad estimate, based on SAMHSA's estimate Medicare pays approximately 7% of substance abuse treatment costs across all settings, would be $154M. This number may be an overstatement if limits on Medicare spending for inpatient psychiatric care extend to substance abuse facilities.
54. "Medicaid--Beneficiaries and Payments: 2000 to 2009" (U.S. Statistical Abstract 2012, http://www.census.gov/compendia/statab/2012/%20tables/12s0151.pdf.) This includes inpatient psychiatric facilities for persons under 21 and mental hospitals for the aged. Medicaid, under a restriction known as Medicaid's Institutions for Mental Disease (IMD) exclusion, does not reimburse psychiatric institutions for services provided to Medicaid enrollees aged 21-64. A review by the National Association of State Mental Health Program Directors Research Institute of state mental health agency-controlled Medicaid revenues for state psychiatric hospitals estimated $2.14B for 2009. (NASMHPD, 2012)
55. This is a very broad estimate based on SAMHSA's estimate Medicaid paid approximately 21% of substance abuse treatment costs across all settings.
56. 2005 data. Includes mental health treatment in specialty units of general hospitals and inpatient specialty hospitals ($11.3B). "Table A.1. Spending by Provider and Setting: Levels and Percent Distribution for Mental Health and Substance Abuse (MHSA), Mental Health (MH), Substance Abuse (SA), Alcohol Abuse (AA), Drug Abuse (DA), and All-Health, 2005." (SAMHSA, National Expenditures, 2010). SAMHSA estimates costs for all inpatient hospital (specialty and non-specialty) MH treatment to be $31.47B for 2006 and $45.45B for 2014. (Levit, 2008)
57. Pennsylvania financial analysis showed in 2010, freestanding psychiatric hospitals had a operating margin of 5.92% and an overall margin for inpatient psychiatric facilities of 4.58% (Pennsylvania Health Care Cost Containment Council, 2011). MedPAC reports hospital-based specialty units, such as psychiatric, historically have had lower profit margins than freestanding.
58. MedPac report (March 2012).
59. "Table 4.2A: Type of care offered, by facility operation and primary focus of facility: 2010" (SAMHSA, N-SSATS, 2010, http://www.samhsa.gov/data/DASIS/2k10nssats/NSSATS2010Tbl4.2a.htm).
60. 2010 data (1649 MH and 2843 SA). These numbers are based on SAMHSA's databases of MH and SA facilities, filtered by residential care (includes both adult and adolescent facilities)--(SAMHSA. Mental health facilities, 2010; SAMHSA. Substance Abuse Facilities, 2010) SAMHSA (Mental Health U.S., 2010) counts 551 residential treatment centers (RTCs) for children with severe emotional disturbance (2008 data) and 55 RTCs for adults (Table 116. "Number of mental health organizations, by organization type, United States and by State, 2008"). The most recently published numbers from SAMHSA's N-SSATS survey (2008) Schwalbe, who defines the RTC as an "RTC, also known as a psychiatric residential treatment facility (PRTF under the federal Medicaid laws and rules) is any non-hospital facility that holds a provider agreement with a state Medicaid agency to provide inpatient services benefit to Medicaid-eligible individuals under the age of 21" (Schwalbe, 2010).
61. Includes 211,000 clients under the age of 18 receiving MH treatment ("Table 56. Number and percentage of persons aged 12-17 who received mental health treatment in the

past year, by type of treatment, United States, 2009," SAMHSA, *Mental Health U.S.*, 2010), and 103,692 clients (including 9302 under the age of 18) receiving SA treatment (http://www.samhsa.gov/data/DASIS/2k10nssats/NSSATS2010Tbl5.2a.htm, N-SSATS, 2010). Although there are numbers for adults receiving SA treatment who have co-occurring MH issues, there are no good United States data on the numbers of adults receiving only MH treatment in adult residential facilities for adults with mental illness. A study published by SAMHSA in 2006, based on September 2003 data, reported results from a survey that received responses from 34 states and the District of Columbia. 63 types of facilities were identified by the survey, with a total of 7,327 facilities with 103,393 beds. State and local MH agencies were responsible for the majority of funding for care in these facilities. Residents also used Supplemental Security Income payments and Social Security Disability insurance payments as funding sources. (Ireys, 2006)

62. Residential care facilities are not eligible to enroll in Medicare. The U.S. Census Bureau estimates $988M in Medicare patient care revenues for residential mental retardation, MH and SA. (Census Bureau, 2010)
63. 2008 data (Schwalbe, 2010). The MAX [Medicaid Analytic eXtract] Chartbook 2008 (Borck, 2012) indicates $488M was spent by Medicaid on residential MH treatment for adults and $2B was spent on residential MH treatment for children and adolescents. PRTF for persons under 21 is a designation for a Medicaid-certified facility. For further information about public spending for residential treatment facilities for children with emotional disturbance, see Ireys et al. (Ireys, 2006).
64. 2005 data. "Table A.1. Spending by Provider and Setting: Levels and Percent Distribution for Mental Health and Substance Abuse (MHSA), Mental Health (MH), Substance Abuse (SA), Alcohol Abuse (AA), Drug Abuse (DA), and All-Health, 2005." (SAMHSA. National *Expenditures for Mental Health Services & Substance Abuse Treatment, 1986-2005*, 2010.) Dobson et al. (NAPHS) estimate $4.5B in direct expenditures for MH services in RTCs for calendar year 2008.
65. Avalere puts the count of CMHCs at 672 (Avalere, 2010). CMS indicates in 2007 there were 224 facilities who billed Medicare for partial hospitalization services, the only treatment covered by Medicare in CHMCs. (CMS, Federal Register 76 FR 35684; June 17, 2011)
66. Behavioral Pathway Systems. "National Council for Community Behavioral Health Care." (2005)
67. 2010 data. HHS, OIG, August 2012.
68. This is the amount of state MH agency-controlled funds for community MH services. ("SMHA Revenues for State Psychiatric Hospitals and Community-Based Programs: FY 2009" NASMHPD Research Institute, August 2012)
69. Ibid. These are "community mental health revenues".
70. This number includes psychologists who are self-employed and those who work in health care facilities. (BLS, 2012)
71. Mental Health, U.S. (2010).
72. U.S. Census Bureau. "Office of Mental Health Practitioners (Except Physicians) (NAICS 62133)" from Table 8.10 of the 2010 Service Annual Survey, "Selected Health Care Services (NAICS 621,622, and 623)--Estimated Revenue for Employer Firms by Source: 2006 Through 2010". [Social work services billed to Medicare for MH services in 2003 were $234M.]
73. Ibid.
74. Based on number practicing multiplied by median wage. SAMHSA indicates total spending for clinical social workers, clinical psychologists, and licensed counselors was $7.6B in 2005. "Spending by provider and setting." (SAMHSA, 2005)
75. 2008 data. 46% of psychologists are in private practice; 12% work in hospital settings; 11% work in other human services setting (clinics, counseling centers, rehab facilities); 4% work in community mental health centers. (Michalski, 2010) A case study based on 2000 data indicate 1% of psychologists work in skilled nursing facilities (Penn State University, "Case Overview," http://lobby.la.psu.edu/007_Clinic_Soc/frameset_clinic_soc.html).
76. Occupational Employment Statistics (BLS, 2011). This number includes health care social workers and MH and SA social workers. Based on estimates by NASW, SAMHSA puts the number of clinically active clinical social workers (2006 data) at 92,227 (Mental Health, U.S. 2010); Avalere puts the number at 260,000 (Avalere, 2010).
77. Based on number practicing multiplied by median wage. (Health care labor statistics by SOC Code, May 2012)
78. The following industries are major employers of health care social workers: Hospitals (state, local, and private)--31%; Nursing and residential care facilities--13%; Individual and family services--11%; Home health care services--10%; Local government--6%; the following industries employed the most MH/SA social workers: Outpatient MH/SA centers--17%; Individual and family services--16%; Hospitals--14%; local government--10%; psychiatric and SA hospitals--8%. (BLS, 2012) A case study based on 2000 data indicate 10% of clinical social workers work in SNFs (Penn State University, "Case Overview," http://lobby.la.psu.edu/007_Clinic_Soc/frameset_clinic_soc.html).
79. Operating 8,147 sites. 2010 data. (GWU, 2012)
80. 2010 data. (Kaiser Family Foundation)
81. 2009 data. (MedPAC, June 2011)
82. Ibid.
83. MedPAC report, June 2011. "In 2007 FQHCs received over $1.6 billion of Section 330 Grants, $335 million of revenue from indigent care programs, and higher reimbursement rates for the $3.9 billion of Medicaid and Medicare receipts because of their FQHC status" (National Council, 2009).
84. January 2012 data. (Muskie School of Public Service, 2012; The George Washington University, 2012)
85. Estimate based on 2008 data. (The George Washington University, 2012)
86. CMS figure for 2010 was $874M. Medicaid Budget and Expenditure System (MBES) CMS-64 data.
87. Based on estimate Medicare and Medicaid provides approximately 60% of RHC funding. (GWU, 2012)
88. Gale and Coburn, 2003.

89. The George Washington University, 2012. "A provider-based RHC is an integral and subordinate part of a Medicare participating hospital, critical access hospital (CAH), skilled nursing facility (SNF), or home health agency (HHA), and is operated with other departments of the provider under common governance, professional supervision, and usually licensure. All other RHCs are considered to be independent" (73 FR 36696; June 27, 2008). Independent clinics are most commonly owned by physicians (49%), other individuals or corporate entities (29%), hospital corporations (15%), nurse practitioners, physician assistants, certified nurse midwives (7%), or RHC administrators (1%). Provider-based clinics are owned by hospitals of less than 50 beds (50%), hospitals of more than 50 beds (40%), and nursing homes and other owners (10%). (Gale and Coburn, 2003)
90. 2008 data (VMG Health, 2010). According to VMG Health analysis, of the total number of freestanding ASCs, 5174 were Medicare-certified. MedPAC data for 2011 indicates there were 5344 Medicare-certified facilities.
91. 2006 data. (Cullen et al., 2009)
92. 2011 data. 2012 proposed rule for ASC payment systems estimates total Medicare ASC payments for CY 2013 would be approximately $4.103 billion, an increase of $211 million over CY 2012. (CMS, Proposed Rule, July 30, 2012)
93. Based on MedPAC data for Medicare expenditures and VMG Health's estimate that Medicaid contributes approximately 5% to ASC revenues (VMG, 2010). A number of studies have shown that lower income individuals tend to receive outpatient surgery treatment in hospital outpatient departments instead of ASCs. (See, for example, Strope, et al., 2009)
94. Based on MedPAC data for Medicare expenditures and VMG Health's estimate that Medicare contributes approximately 25% to ASC revenues. (VMG, 2010)
95. MedPAC is unable to calculate a Medicare margin because ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Pennsylvania financial analysis of ASCs operating in their state estimated an average margin of 26.3% in 2010. (Pennsylvania Health Care Cost Containment Council, 2011)
96. American Ambulatory Surgery Association.
97. VMG Health, 2010.
98. United States Renal Data System (USRDS), 2011. "Chapter 10: Providers" USRDS data is for 2009; MedPac figure for 2010 was 5500 facilities.
99. USDRS (2011). The number of patients given in the Medicare and Medicaid Statistical Supplement 2011 is 387,000. MedPAC's number of Medicare patients in 2010 was 335,000.
100. 2009 USRDS data. "Report by the Numbers" (Renal Business Today, 2011). Numbers vary widely by source, probably dependent upon whether drug costs are bundled into the total. MedPAC's figure is $9.5B (MedPAC, March 2012). The GAO figure is $7.9B. (GAO, ESRD, 2006)
101. USRDS "Report by the Numbers" (Renal Business Today, 2011).
102. Margins vary based on size and geography. (MedPAC, June 2012)
103. GAO, 2006.
104. MedPAC, June 2012.
105. National Highway Traffic Safety Administration, 2011.
106. CMS Data Compendium, December 2010.
107. This number is for "transportation services" so probably includes more than emergency services. Medicaid Statistical Information System, 2009 data.
108. CMS. National Health Expenditures Accounts: Definitions, Sources, and Methods, 2009.
109. GAO, 2012.
110. 2004 data. These numbers are based on the GAO's analysis of Medicare-certified ground ambulance services. (GAO, 2007)
111. SK&A, 2012.
112. CMS Data Compendium, December 2010.
113. Ibid. A report from the OIG of HHS put Medicaid expenditures for prescription drugs in 2009 at $26B. (Levinson, 2011)
114. "National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years 1960-2010" (CMS, National Health Expenditures Data, 2010).
115. SK&A, 2012.
116. Midwest Pharmacy Workforce Research Consortium, 2009.
117. BLS, "Pharmacists", 2012.
118. CMS CLIA Update, July 2012. The number on the CMS website is 225,000 (CMS, CLIA website).
119. 2011 data. $4.6B Independent and physician office-based; $4.4B hospital-based. (MedPAC, June 2012)
120. CMS-64 data. Includes radiology. (CMS, Financial Management Report, 2010)
121. RNCOS, 2012.
122. Ahn et al., 1997. CMS' Division of Laboratory Services provides the following breakdown of laboratories by type of facility--50.06% physician office, 6.39% nursing facility, 6.13% HHA, 3.78% hospital, 3.29% pharmacy, 2.74% community clinic, 2.28% ESRD, 2.28% ASC, 2.4% independent. The following facility types made of less than 2% of the CLIA database--ambulance, ancillary test site, assisted living facility, blood banks, comprehensive outpatient rehabilitation, FQHC, health fair, HMO, hospice, industrial, insurance, ICFMR, mobile laboratory, other practitioner, prison, public health laboratory, RHC, school/student health service, and tissue back/repository. 8.71% of

laboratories were classified as other. (CMS, CLIA Update, July 2012)

123. FDA Blood Establishment Registration Database. Filtered by an establishment status of "Active". More than one category may apply to a facility. (FDA, 2012)
124. Number of transfusions (2008). (HHS, National Blood Collection Report, 2009)
125. Ibid. Most Medicare reimbursement for blood is part of the diagnosis-related group (DRG) payment made for inpatient services. Other payers, besides Medicare, pay for blood using varying mechanisms.
126. Ibid. Blood centers were responsible for 93.8% of total blood units collected, hospitals 6.2%.
127. "Table 113: Health care employment and wages, by selected occupations: United States, selected years 2001–2010". (NCHS, 2012, http://www.cdc.gov/nchs/data/hus/2011/113.pdf)
128. "Offices of Physical, Occupational and Speech Therapists, and Audiologists (NAICS 62134)" from Table 8.10 of the 2010 Service Annual Survey, "Selected Health Care Services (NAICS 621,622, and 623)--Estimated Revenue for Employer Firms by Source: 2006 Through 2010." (U.S. Census Bureau, 2010)
129. Ibid.
130. Ibid.
131. Physical therapists typical employment affiliations: Offices of health practitioners (37%); Hospitals; state, local, and private (28%); Home health care services (10%); Nursing and residential care facilities (7%). About 7% of physical therapists were self-employed in 2010. Occupational therapists typical employment affiliations: Hospitals; state, local, and private (27%); Offices of physical, occupational and speech therapists, and audiologists (21%); Nursing care facilities (9%); Home health care services (7%); Individual and family services (3%). Speech-language pathologists typical employment affiliations: Elementary and secondary schools; state, local, and private (44%), Offices of physical, occupational and speech therapists, and audiologists (15%), Hospitals; state, local, and private (13%), Nursing care facilities (4%), Home health care services (3%). (BLS, 2012)
132. "Table 113: Health care employment and wages, by selected occupations: United States, selected years 2001–2010". (NCHS, 2012, http://www.cdc.gov/nchs/data/hus/2011/113.pdf)
133. $4.8M spent on diabetes self-management training by dietitians. Medicare also covers direct billing for medical nutrition therapy performed by dietitians. The regulatory impact analysis of Medicare reimbursement to dietitians and nutrition professionals providing diagnostic therapy and counseling services related to medical nutrition therapy estimated a cost of $70M in FY 2006. (CMS, 2001)
134. Figure is a broad estimate, based on the number of practitioners times the average salary. (Highbeam, SIC 8049, 2012)
135. Dietitians typical places of employment: Hospitals; state, local, and private--32%; Nursing care facilities--8%; Outpatient care centers--6%; Offices of physicians--4%. They also work in cafeterias, schools, and some are self-employed. (BLS, 2012)

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EHR PAYMENT INCENTIVES FOR PROVIDERS INELIGIBLE FOR PAYMENT INCENTIVES AND OTHER FUNDING STUDY

Files Available for This Report

Main Report
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI.shtml
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI.pdf

APPENDIX A. Medicare and Medicaid EHR Incentive Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendA
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendA.pdf

APPENDIX B. Definitions and Certification of EHR Technology
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendB
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendB.pdf

APPENDIX C. Public Health Service Act Section 3000(3) as Added by HITECH Section 13101 -- Provider Analysis
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendC
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendC.pdf

APPENDIX D. Ineligible Provider Characteristics
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendD
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendD.pdf

APPENDIX E. Long-Term and Post-Acute Care Provider Profiles
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendE
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendE.pdf

APPENDIX F. Behavioral Health Provider Profiles
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendF
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendF.pdf

APPENDIX G. Safety Net Provider Profiles
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendG
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendG.pdf

APPENDIX H. Other Health Care Provider Profiles
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendH
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendH.pdf

APPENDIX I. Table Summary of Patient Protection and Affordable Care Act Provisions with Relationship to Ineligible Providers and Health IT Use
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendI
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendI.pdf

APPENDIX J. Behavioral Health Provider Analysis
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendJ
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendJ.pdf

APPENDIX K. Grant, Demonstrations and Cooperative Agreement Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendK
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendK.pdf

APPENDIX L. Loan Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendL
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendL.pdf

APPENDIX M. Technical Assistance Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendM
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendM.pdf

APPENDIX N. Administrative Infrastructure Building Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendN
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendN.pdf

APPENDIX O. Anti-Kickback Statute EHR Safe Harbor Regulations
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendO
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendO.pdf

APPENDIX P. Private Sector Programs to Advance Certified EHR Technology
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendP
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendP.pdf

APPENDIX Q. Regulations for Medical Records
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendQ
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendQ.pdf

APPENDIX R. Technical Advisory Group Summary
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendR
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendR.pdf

APPENDIX S. Evaluating Benefits and Costs of New Incentives for EHR Adoption by Ineligible Providers
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendS
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendS.pdf

APPENDIX T. CIO Consortium EMR Cost Study Data
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendT
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendT.pdf

APPENDIX U. Abbreviations and Acronyms
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendU
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendU.pdf

APPENDIX V. References
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendV
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendV.pdf