U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

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

June 2013

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ABSTRACT

Background

This study was conducted in response to a requirement in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111-5). Title IV of Division B of ARRA directs the Secretary to conduct several studies including the study described in Section 4104(a):

> The Secretary of Health and Human Services shall conduct a study to determine the extent to which and manner in which payment incentives (such as under Title XVIII or XIX of the Social Security Act) and other funding for purposes of implementing and using certified EHR technology (as defined in Section 1848(o)(4) of the Social Security Act, as added by Section 4101(a)) should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, under Title XIII of Division A under Title XVIII or XIX of such Act, or otherwise, for such purposes.
>
> (B) DETAILS OF STUDY. -- Such study shall include an examination of --
>
> (i) the adoption rates of certified EHR technology by such health care providers;
> (ii) the clinical utility of such technology by such health care providers;
> (iii) whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology;
> (iv) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act, under Title XIII of Division A, under Title XVIII or XIX of the Social Security Act, or other;
> (v) the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and
> (vi) any other issues the Secretary deems to be appropriate.

The Centers for Medicare and Medicaid Services (CMS) made available ARRA/HITECH funds to the Office of the Assistant Secretary for Planning and Evaluation (ASPE), in the Office of the Secretary within the U.S. Department of Health and Human Services, to conduct the study required in Section 4104(a). The study was directed and managed by ASPE. ASPE awarded a contract to the American Health Information Management Association (AHIMA) to complete the study. The study addresses the questions in Section 4104(a).

Findings and Conclusions of the Study

1. Health care providers not eligible for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (referred to as the EHR Incentive Programs) can be organized into four clusters: Long-Term and Post-Acute Care (LTPAC); Behavioral Health; Safety Net; and Other. Generally, these health care providers provide health care services to some of the most vulnerable and costly individuals in our society, and the care they deliver would often benefit from electronic communication with other providers.

2. The funding made available under ARRA/HITECH (e.g., funding for demonstration grants, cooperative agreements, etc.) to health care providers not eligible to participate in the EHR Incentive Programs is not expected to support widespread adoption and use of EHR technologies (including certified EHR technologies) by these ineligible providers. The one exception to this finding pertains to the $1.5 billion made available under the ARRA to Health Resources Services Administration for health centers that include support for the acquisition of health information technology (health IT) systems.

3. Implementation of provisions in the Affordable Care Act may support the use health IT by health care providers not eligible for the EHR Incentive Programs and bring new market pressures on these providers to use such technologies and electronically exchange health information.

4. Implementation rates of EHR technologies, including implementation of certified EHR technologies, by providers not eligible to participate in the EHR Incentive Programs are lagging behind that of health care providers who may participate in the EHR Incentive Programs (i.e., eligible professionals and eligible hospitals).

5. Nonetheless, many health care providers not eligible to participate in the EHR Incentive Programs are adopting some level of technology to meet their clinical and business needs.

6. Providers not eligible to participate in the EHR Incentive Programs generally provide health care to some of the most vulnerable and costly individuals in our society, and the care they deliver would benefit from the use of EHR technology, including the ability to communicate electronically with other providers. The need for health information exchange is particularly important given the multiple providers often involved in caring for these patients, and the number of transitions in care experienced by patients treated by these health care providers.

7. A minority of providers not eligible to participate in the EHR Incentive Programs may be affiliated with health care providers/organizations that are eligible to receive incentive payments under the Medicare and Medicaid EHR Incentive Programs. However, these relationships have not supported widespread use of

certified EHR technology by providers not eligible to receive incentive payments, in part, because currently available certified EHR technology does not support the clinical and business needs of providers who are not eligible for EHR incentives.

8. Activities are underway to fill gaps in health IT standards to support the interoperable exchange of documents at times of transitions in care and care plans during transitions in care as well as when care shared across multiple clinicians.

9. Various stakeholders have suggested options that could be considered to support implementation of certified EHR technologies by health care providers who are not eligible to participate in the EHR Incentive Programs. These options include:
   a. Direct support such as making available:
      i. financial assistance (e.g., through incentives, grants (including demonstration grants) or loans) to support the acquisition and use of certified EHR technology; and/or
      ii. technical assistance to support the acquisition and use of this technology.

   b. Indirect support such as:
      i. further development of the nationwide health IT infrastructure to allow for the electronic use and exchange of interoperable information needed to provide services to persons served by these health care providers; and
      ii. extending various Medicare and Medicaid authorities to support implementation of health information technologies, including certified EHR technologies, by health care providers who are not eligible to participate in the EHR Incentive Programs.

10. Strategic planning and coordination across programs is needed to identify the most promising policy options, and support successful implementation and use of certified EHR technologies by health care providers who are not eligible to participate in the EHR Incentive Programs. Some of the factors that should be considered in evaluating the costs and benefits of different options include:

    a. *Built to last:* Interventions should support the technology infrastructure needed for the emerging health care delivery and business models envisioned in the Affordable Care Act, the nationwide health IT infrastructure, and EHR Incentive Programs to allow for the interoperable exchange and reuse of health information.
    b. *Patient-centered:* Interventions should promote a patient-centered approach to care delivery and outcomes.
    c. *Tailored and targeted*: The need for interventions should be evaluated in terms of the clinical utility of the technology by a range of health care

providers. It is likely that different technology solutions will be required to achieve policy goals.

d. *Smartly clustered*: Interventions may need to be clustered to accrue the most benefit from the investment.
e. *Spend wisely:* Consideration should be given to the costs of technology (which are declining) and providers' margins and ability to cover all or some of these costs.

Conclusions of the Study

Many of the health care providers not eligible for the Medicare and Medicaid EHR Incentive Programs, such as LTPAC and Behavioral Health providers, have a frequent need to exchange health information on behalf of their patients, who are among the most vulnerable and costly in our society. One of the key benefits of the use of health IT is the ability to exchange information to communicate and coordinate services on behalf of patients, and their physicians and entire care team who are often located in different geographic areas and practice settings. Advancing the adoption of certified EHR technology solutions by providers not eligible for the EHR Incentive Programs may support the realization of the goals associated with implementing a nationwide health IT infrastructure, new models of care delivery and coordination, and the Medicare and Medicaid EHR Incentive Programs.

Filling critical gaps in standards is important to support the interoperable exchange of health information on behalf of vulnerable persons who receive services across the care continuum, including (but not limited to) health care providers who are not eligible for the EHR Incentive Programs. In addition, the specification of standards to support interoperable health information exchange is necessary but may not be sufficient to support the development and implementation of certified EHR technology solutions for these providers. Other actions will likely be needed to support and accelerate the use of certified EHR technology by health care providers not eligible for the EHR Incentive Programs.

EXECUTIVE SUMMARY

The Health Information Technology for Economic and Clinical Health Act (HITECH) includes Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111-5) (ARRA). It is estimated that pursuant to HITECH, over $15 billion[1] in incentive payments for the adoption and meaningful use of certified electronic health record technology (CEHRT) will be available between 2014 and 2019 to help certain health care providers improve the quality, safety, and coordination of care while also achieving efficiency gains to help control costs. HITECH-designated hospitals, physicians, and others as eligible for financial incentives for the adoption and meaningful use of CEHRT. Other categories of providers are ineligible. In addition, Title VIII of Division A of the ARRA made available $2 billion to the Office of the National Coordinator for Health Information Technology (ONC) to carry out activities in HITECH, including the development of a nationwide health IT infrastructure that allows for the electronic use and exchange of health information. Through these HITECH provisions, certain providers are eligible for incentive payments and other funding to support their adoption and use of electronic health record (EHR) technology as a part of the emerging nationwide health IT infrastructure.

However, Congress recognized the importance of providers not eligible for EHR incentive payments or other funding to support the implementation of the nationwide health information technology (health IT) infrastructure. Section 4104(a)[2] of the HITECH Act required the Secretary of Health and Human Services (HHS) to conduct a study to determine the extent and manner in which payment incentives and other funding for implementing and using certified EHRs should be made available to those providers who received minimal or no HITECH payments. The study is required to address the following factors:

- the extent to which ineligible providers work in settings that might otherwise receive an incentive payment or other federal funding under ARRA, the Social Security Act, or otherwise;

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[1] HITECH authorized the Medicare and Medicaid EHR Incentive Programs. The Centers for Medicare and Medicaid Services (CMS) estimate that between 2014 and 2019 $15.4 billion will be made available in incentive payments. This estimate: (i) includes net payment adjustments in the amount of $2.1 billion for Medicare providers who do not achieve meaningful use in 2015 and subsequent years; and (ii) does not include estimates of the benefits of participating the Medicare and Medicaid EHR Incentive Programs. (http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf, p.53971, September 4, 2012.)

[2] Section §4104(a): "The Secretary of Health and Human Services shall conduct a study to determine the extent to which and manner in which payment incentives (such as under Title XVIII or XIX of the Social Security Act) and other funding for purposes of implementing and using certified EHR technology (as defined in Section 1848(o)(4) of the Social Security Act, as added by Section 4101(a)) should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, under Title XIII of Division A, under Title XVIII or XIX or such Act, or otherwise, for such purposes."

- adoption rates of certified EHR technology (CEHRT) by ineligible providers;
- clinical utility of such technology for ineligible providers;
- whether the services ineligible providers furnish are appropriate for or would benefit from such technology;
- the potential costs and benefits of making payment incentives and other funding available to ineligible providers; and
- any other issues the Secretary deems appropriate. For purposes of this study we identified the extent to which options and incentives had been proposed or implemented to support the use of the technology, including use by ineligibles.

The Secretary is required to submit a report to Congress on the findings and conclusions of this study.

The use of health IT by all health care providers has become increasingly important. Although the Patient Protection and Affordable Care Act of 2010 (Pub.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub.L. 111-152) (collectively known as the Affordable Care Act)) does not provide funds to support technology acquisition costs, implementing many of its value based purchasing and delivery model provisions as well as other provisions depends heavily upon a health IT/EHR infrastructure.[3] In 2011, the National Quality Strategy Report to Congress similarly identified increased use of health IT as one of ten principles to adhere to when designing initiatives to bring about better care, healthy people and healthy communities, and affordable care. In addition, the growing sophistication of health IT applications developed by the private sector underscores the importance of the use of technology to support the health and health care of every American.[4]

Ineligible Providers

We identified health care providers as those listed in Section 3000(3) of the Public Health Service Act, as added by Section 13101 of HITECH. Those providers identified as ineligible for Medicare and Medicaid EHR incentives and the focus of this report were organized into four clusters: Long-Term and Post-Acute Care (LTPAC); Behavioral Health; Safety Net; and Other, as shown in Table 1 below. As described below, we also considered the extent to which these ineligible provider types received other funding to support their use of EHR technology.

This study identified over 54,000 ineligible provider organizations and 344,000 ineligible professionals delivering services to 51 million individuals across the United

[3] Appendix I identifies some of the ACA provisions that: (i) pertain to some of the providers ineligible for the EHR Incentive programs; and (ii) require or support the use of health IT and/or health information exchange.

[4] Report to Congress: National Strategy for Quality Improvement in Health Care, March 2011. http://www.healthcare.gov/news/reports/quality03212011a.htm.

States. This summary statistic excludes those ineligible providers clustered in the "Other Provider" category above due to challenges with comparability. Although some of the ineligible providers have an ownership affiliation with eligible providers (and therefore potential access to EHR incentive funds), the majority do not.

TABLE 1. Ineligible Providers by Cluster in Alphabetical Order			
Long-Term & Post-Acute Care (LTPAC)	**Behavioral Health (BH)**	**Safety Net Providers (FQHC and RHC)**	**Other**
- Home health agency (HHA) - Hospice - Inpatient rehabilitation facility (IRF) - Intermediate care facility for individuals with intellectual disabilities (ICF/IID) - Long-term care hospital (LTCH) - Nursing home (SNF/NF)	- Clinical social worker - Community mental health center (CMHC) - Psychiatric hospital/unit (including substance abuse) - Residential treatment centers (facilities for mental health and/or substance abuse) - Psychologist	- Federally qualified health center (FQHC) - Rural health clinic (RHC)	- Ambulance Service - Ambulatory surgical center (ASC) - Blood center - End stage renal disease (ESRD) dialysis center - Laboratory - Dietitian/nutritionist - Pharmacist - Pharmacy - Therapist (physical, occupational, speech)

Services delivered by these LTPAC, behavioral health, and FQHC/RHC providers account for $181 billion in combined Medicare and Medicaid expenditures -- over 20 percent of the total Medicare and Medicaid expenditures in health care.[5] Safety net providers deliver care to a large number of patients as a primary care provider. Among the LTPAC, Behavioral Health, and Safety Net providers, this study found the provider types accounting for the largest share of Medicare and Medicaid expenditures were: nursing home, home health care, and community mental health providers.

We considered whether the ineligible provider types received other funding under HITECH for purposes of implementing and using EHR technology. With the exception of funds provided to certain safety net providers for their use of health IT, the other funding (e.g., demonstration grants) made available to certain ineligible provider types is not expected to support widespread adoption and use of EHR technology by these ineligible providers.

The Medicare and Medicaid EHR Incentive Programs authorized by HITECH (also referred to as the EHR Incentive Programs) have been successful in accelerating the use of EHR technology by eligible hospitals and professionals. The EHR Incentive Programs increasingly require that providers eligible for incentives engage in health information exchange (HIE). Transitions in care between providers eligible for incentives and providers who are not eligible are common. For example, in 2008,

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[5] National Health Care Expenditure Data for 2009. Centers for Medicare and Medicaid Services. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html.

almost 40 percent of all Medicare beneficiaries discharged from acute care hospitals received post-acute care; and of these beneficiaries, more than 15 percent were readmitted to the acute care hospital within 30 days of hospital discharge.[6] Instances of shared care are also common between eligible and ineligible providers. For example, Medicare requires that both the physician and HHA sign a home health plan of care. Thus, the normal course of patient care necessitates that eligible providers will exchange health information with ineligible providers. Some providers not eligible for EHR incentives are also adopting EHR technology, but those EHRs are not necessarily compliant with the EHR Incentive Programs criteria used by eligible hospitals and physicians, including requirements that would support interoperable HIE and health information reuse. Effective communication and information sharing across all providers is essential to improving the quality of care, bettering health of communities, and lowering per capita costs. Better alignment of the health IT solutions used by eligible and ineligible providers could promote better HIE and affect health care quality and the ability of eligible providers participating in the EHR Incentive Programs to engage in electronic exchange and care coordination activities with ineligible providers.

In addition to the EHR Incentive Programs, this study identified relationships between ineligible providers and provisions of the Affordable Care Act that could support the use of health IT and/or HIE by these ineligible provider types. We found 40 provisions of the Affordable Care Act that apply to providers not eligible for the EHR Incentive Programs and either require or support the use of health IT and/or HIE with or by these providers. Many of these HIE provisions will advance new care and service delivery models to improve care coordination and quality. Most of these provisions will engage one or more of the ineligible provider types who may not have the health IT infrastructure that could support the reform activity. As these provisions are implemented, new market pressures on ineligible providers to use health IT may increase.

EHR Adoption Rates for Ineligible Providers

This study identified a number of important facts about ineligible providers and their use of EHR technology. Four are particularly salient:

- ineligible providers generally provide health care to individuals who are among the most vulnerable and costly individuals in our society;
- the care they deliver would often benefit from electronic communication with other providers, but that remains uncommon;
- most are adopting some level of technology to meet clinical and business needs, but are not investing in interoperable technology that supports a patient-centered approach; and

[6] Gage, B. et al. "Post-Acute Care Episodes Expanded Analytic File. Final Report. April 2011." Prepared for the Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/health/reports/2011/pacexpanded/index.shtml#ch1.

- EHR technology products currently used by ineligible providers often are not certified to HHS-adopted standards and criteria, and thus lack interoperability and HIE capabilities, particularly for LTPAC and behavioral health providers.

Collecting information on health IT adoption by the ineligible providers presented significant challenges due to the lack of comparable survey tools, inconsistent definitions and peer-reviewed studies. For ineligible providers, EHR adoption rates ranged from 4 percent to 65 percent. The adoption rates for ineligible providers cannot and should not be compared to adoption rates for eligible hospitals and eligible physicians since they do not measure adoption rates of comparable EHR technology. To illustrate the lack of comparability, the findings from the June 2012 study on health IT adoption for community behavioral health organizations reports that 21 percent of these organizations have EHRs at all of their sites, and 65 percent of survey respondents reported having adopted some form of an EHR at least at some of their sites. Only 2 percent of responding community behavioral health organizations reported adopting technology that could meet the base requirements of the EHR Incentive Program.[7]

Addressing this technological lag by ineligible providers could support deployment of new models of care delivery and coordination and new payment models for the vulnerable populations most likely to benefit from the service delivery system improvements.

Current and Proposed Initiatives

In this study, more than 30 actions were identified that have been proposed for or implemented in federal or state initiatives that could support (in various amounts, duration, and scope) the use of health IT/EHR technology by ineligible providers.[8] The initiatives are categorized in terms of programs that provide "Direct Support" or "Indirect Support" to ineligible providers.

[7] "HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health." National Council for Community Behavioral Healthcare. http://www.thenationalcouncil.org/galleries/business-practice%20files/HIT%20Survey%20Full%20Report.pdf.

[8] The initiatives are described in Appendix A and Appendices K-N. In the course of identifying current federal and state initiatives, we identified some private sector programs and highlighted those in Appendix P.

Direct Support	Indirect Support
- Proposals to extend the HITECH EHR Incentive Programs - Health IT grants to support health IT acquisition - Health IT loan program - Technical assistance programs for EHR technology implementation consulting - Cost report subsidy	- Health IT grants to states for infrastructure development and outreach - Health IT grants to community groups and providers to demonstrate health IT solutions that support new models of care delivery and HIE - Technical assistance resources and toolkits for EHR implementation - Infrastructure development--policy and health IT standards - Anti-Kickback Statute EHR Safe Harbor

Evaluating Intervention Options

The 30-plus initiatives mentioned above for advancing health IT for ineligible providers could be coordinated more closely to advance common goals. Based on our analysis and consultation with the Technical Advisory Group (TAG) convened by the contractor for this study, there are some guiding principles that could be considered when evaluating whether action is needed for purposes of implementing and using EHR technology by the ineligible providers:

- *Built to last*: Interventions should support the development of the emerging health care delivery and business models envisioned in the Affordable Care Act, the nationwide health IT infrastructure, and the EHR Incentive Programs.

- *Patient-centered*: Interventions should support improved care delivery and outcomes through the patient-centered approach that technological change is increasingly enabling.

- *Tailored and targeted*: Interventions should not be one-size-fits-all, but selected with an understanding of ineligible providers and the technology solution needed to achieve policy goals.

- *Smartly clustered*: Interventions should be strategically focused and clustered to get the most benefit from the investment.

- *Spend wisely*: In today's fiscally constrained environment careful consideration should be given to the need to support widespread implementation and use of health IT/EHRs by ineligible providers. Such considerations should take into account the ineligible provider's profit margins and ability to pay for some of the technology, and the availability of and need for additional funding to support the acquisition and use of health IT/EHR solutions that will support programmatic and policy goals.

Targeting Ineligible Providers

Not all ineligible providers need CEHRT, nor are all categories of ineligible providers equally critical in achieving overall health system improvements. This study provides guidance and suggested evaluation factors that could be used to determine which providers to prioritize. The TAG considered the factors and prioritized the ineligible providers into following three groupings:

- *Safety net providers*: Ineligible safety net providers have already been prioritized for additional support. Safety net providers deliver primary care services to nearly 26 million individuals[9] in rural and underserved areas. Congress previously addressed this group of ineligible providers, not through an extension of the HITECH incentive program, but through a $1.5 billion appropriation to Health Resources and Services Administration for health IT grant funding to support the adoption and use of EHR technology for health centers. This funding, which has not been available to the other ineligible providers, has resulted in a relatively high rate of EHR technology adoption for safety net providers.

- *Long-term and post-acute care and behavioral health providers*: Policymakers have directed some attention at advancing the use of health IT/EHRs by the LTPAC providers and behavioral health providers. For example, in 2012 the Substance Abuse and Mental Health Service Administration (SAMHSA) directed $23 million[10] in grants and contracts towards the health IT infrastructure and the use of health IT/EHRs by behavioral health providers. In addition, ONC directed $7 million in State Health IT Challenge Grants to advance HIE on behalf of LTPAC providers, and is also supporting HIE on behalf of LTPAC providers in some of the Beacon Community Programs. These providers serve some of the nation's most vulnerable individuals on behalf of whom a significant portion of Medicare and Medicaid expenditures are made. These patients experience frequent transitions in care and require care coordination with eligible hospitals and professionals, and other health care providers. Some of these providers will need interoperable EHR technology to support new care delivery and payment models in the Affordable Care Act (as identified in Appendix I) and in private sector initiatives.

- *Other ineligible health care providers*: The use of certain technology interventions could be targeted, as needed, to other ineligible providers to advance policy priorities such as e-prescribing, medication management or lab reporting. These providers are either ancillary service providers that may

[9] FQHC serve 19.4 million patients. (The Henry J. Kaiser Family Foundation. "Patients Served by Federally-Funded Federally Qualified Health Centers, 2010." http://www.statehealthfacts.org/comparebar.jsp?ind=426&yr=138&typ=1&sort=a&rgnhl=15.)

Using data from 2008, the total number of patients seen in RHCs is estimated to be between 5 and 8 million. For purpose of this report we use the average of this range (i.e., 6.5 million patients per year). (The George Washington University, 2012, p.51, http://www.healthit.gov/sites/default/files/pdf/quality-incentives-final-report-1-23-12.pdf.)

[10] Total grant and contract funding for 2012 provided by SAMHSA staff. (September 12, 2012.)

interface with an EHR or generally have access to CEHRT through their work in other settings. Supporting the use of interoperable interventions through the development of specialized applications would permit efficient HIE between these ancillary providers and health care providers that require the use of certified EHRs, including those providers who are presently eligible for the EHR Incentive Programs.

Economic Factors for Evaluating Options

The decision to implement technology by a provider or implement an incentive or funding program is dependent on understanding the benefits and costs. This section identifies economic factors for evaluating the benefits and costs of programs to accelerate adoption of interoperable EHR technology by ineligible providers. We do this by addressing:

- key principles of cost-benefit analysis;
- findings from evidence on the effectiveness of EHRs;
- criteria for evaluating the costs and benefits of a program; and
- considerations to promote interoperability.

The criteria developed for this report identify several economic factors that could:

- inform the need for and impact of incentives and/or other funding to support the use of EHRs by ineligible provider types; and
- be used to evaluate the need for, and costs and benefits of different incentives and other options to encourage health IT adoption by ineligible providers.

This study considers some of these factors in assessing the potential impact of extending three incentive/funding options and applies the criteria to a private sector study that identifies hypothetical nursing home costs of EHR acquisition and use.

Overall Findings

LTPAC, Behavioral Health, Safety Net, and other providers are not eligible for EHR incentive payments under the Medicare and Medicaid EHR Incentive Programs. Ineligible providers generally provide health care to vulnerable and costly individuals in our society, and the care they deliver would often benefit from electronic communication with other providers. However, such HIE remains uncommon, and addressing this technological lag could support the realization of the goals associated with implementing a nationwide health IT infrastructure and the deployment of new models of care delivery and coordination, and support the HIE goals of the Medicare and Medicaid EHR Incentive Programs.

The ability to address this problem is hindered by data on ineligible providers' health IT use that are unreliable or unavailable, not comparable among ineligible provider types or between any or all of those provider types and the eligible providers involved in the EHR Incentive Program. Despite those barriers, this study addressed the specific questions asked by Congress. This study has:

- provided a rationale for defining health care providers and identified those who are not eligible for the Medicare and Medicaid EHR Incentive Programs, and grouping them into different categories;
- identified other funding made available to these providers who are ineligible for the EHR Incentive Programs and with the exception of certain safety net providers, found that the amount, duration and scope of these other funds will not support widespread use of technology needed to support national policy goals;
- described, to the extent possible, the key characteristics and clinical use of health IT by ineligible providers;
- considered the extent to which ineligible providers work in settings that might otherwise receive EHR incentive payments;
- considered, but could not determine, whether market forces associated with new delivery models such as those encouraged by the Affordable Care Act will be sufficiently widespread to drive adoption of interoperable technologies; and
- identified factors for considering the costs and benefits of making available health IT/EHR incentives/funding for ineligible providers who may be determined to need such support to support national policy goals related to improving health and health care.