APPENDIX E. LONG-TERM AND POST-ACUTE CARE PROVIDER PROFILES

This appendix provides the clinical characteristics and EHR summary (EHR use, clinical utility, barriers) data for the following long-term and post-acute care providers. Definitions for the provider types are found in Appendix C.

A. Nursing homes (SNF/NF)
B. Inpatient rehabilitation facilities (IRF)
C. Long-term care hospitals (LTCH)
D. Home health agencies (HHA)
E. Hospice
F. Intermediate care facilities for persons with intellectual disabilities (ICF/IID)

A. Nursing Homes

A nursing home (either a skilled nursing facility (SNF) or nursing facility (NF)) is an institution or a distinct part of an institution that has in effect a transfer agreement with one or more hospitals and is primarily engaged in providing: skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation of injured, disabled, or sick persons; meets detailed requirements relating to services provided, residents' rights, professional standards, health and safety standards, and notification to the state of changes in ownership and control; and is not primarily for the care and treatment of mental diseases (and in the case of NFs provides health related care and services to individuals who because of their mental and physical condition can only be made available to them through an institutional facility).[1,2] Nursing homes have a permanent core staff of registered or licensed practical nurses who, along with other staff, provide nursing, therapy, and continuous personal care services.[3]

[1] Social Security Act. http://www.ssa.gov/OP_Home/ssact/title19/1919.htm.

[2] Social Security Act. http://www.ssa.gov/OP_Home/ssact/title18/1819.htm.

[3] U.S. Census Bureau. http://www.census.gov/econ/industry/def/d623110.htm.

Nursing Homes' Characteristics	
No. of providers	15,716 NHs[a]
Description	Nursing homes are inpatient facilities that provide nursing services to provide for the physical, mental and psychosocial well-being of each resident through a multi-disciplinary approach via nurses, therapists and other related professionals. Many of these facilities are dually-certified under both Medicare and Medicaid (91.5%).
Other names	Skilled nursing facility (SNF), nursing facility (NF), sub acute unit, transitional care unit, LTC facility.
Number of patients	1,385,955 patients.[b]
Description of patients	Typical nursing home patients require assistance and care on a daily basis, and a large number of these patients are Medicare beneficiaries.
Revenue	$143.1 Billion[a]
Owned by eligible provider	6.4% are hospital-based[c]
Medicare profit margin	18.5%[d]

a. CMS. National Health Expenditures (2010).
b. 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.)
c. CMS 2011 Data Compendium. "Table VI.1: Medicare Hospital and SNF/NF/ICF Facility Counts, November 2011." http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011_Data_Compendium.html.
d. 2011 data (MedPAC, June 2012).

Nursing Homes' Health IT Use, Clinical Utility and Barriers		
EHR Needed	Yes	
Adoption Rate	43%[a]	
Use in Practice	- Admission, discharge and transfer (ADT) - Appointments - Order entry and management - Clinical notes - Assessments - Care Plan - Condition specific documentation	- Medication and treatment records - Pharmacy information system - Lab information system - Therapy information system - Patient Portals - Patient eligibility determinations - Billing - Staffing, Payroll, and HR
Clinical Utility	- Patient Demographic, Health Information and Problem Lists - Clinical Decision Support - Physician Order Entry - Support Clinical Quality Measures	- Exchange health information (send, receive and integrate) - Privacy, Security and Integrity Features
Need for Information Exchange	High, as patients may transition from the nursing home to primary care facilities and/or emergency care facilities several times each year.	
Barriers to Adoption	- Cost to adopt/lack of capital/lack of incentives - Lack of awareness of the need to implement an EHR - Lack of a certified vendor for provider specialty - EHRs available lack of alignment with MU criteria	- Workforce limitations to implement and maintain an EHR - Limited decision support for complex clinical condition - Lagging standards for clinical processes

a. Resnick, H.E., Manard, B.B., Stone, R.I., Alwan, M. "Use of Electronic Information Systems in Nursing Homes: United States, 2004." *Journal of the American Medical Informatics Association (JAMIA)*, 2009, 16: 179-186. Abstract available online at http://jamia.bmj.com/content/16/2/179.abstract.

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Resnick, H.E., Manard, B.B., Stone, R.I., Alwan, M. "Use of Electronic Information Systems in Nursing Homes: United States, 2004." *Journal of the American Medical Informatics Association (JAMIA)*, 2009, 16: 179-186. Abstract available online at http://jamia.bmj.com/content/16/2/179.abstract.

B. Inpatient Rehabilitation Facilities

An inpatient rehabilitation facilities (IRF) provides intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF.[4]

[4] Centers for Medicare and Medicaid Services. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf.

Inpatient Rehabilitation Facilities' Characteristics	
No. of providers	1,179[a]
Description	An inpatient rehabilitation hospital or facility is one that provides intensive rehabilitation services to patients after injury, illness, or surgery. These facilities provide physical and occupational therapy, rehabilitation nursing, prosthetic and orthotic services, as well as speech-language pathology, and about 80% of these facilities were specialized units within hospitals.
Other names	Rehab unit, inpatient rehabilitation facility
No. of patients	397,256[a]
Description of patients	95% of patients are transferred from acute care hospitals into these facilities, and require intensive care after injury, illness, or surgery. Medicare is the predominant payor of IRF services, accounting for about 60% of all discharges.
Revenue:	$11.0 Billion[a]
No. owned by eligible provider	80% hospital-based[b]
Medicare profit margin	8.8% (varies greatly from one facility to another)[a]
a. MedPAC. *Report to the Congress. Medicare Payment Policy*, March 2012. b. MedPAC, March 2012.	

Inpatient Rehab Hospitals Health IT Use, Clinical Utility and Barriers		
EHR Needed	Yes	
Adoption Rate	4%[a]	
Use in Practice	- Admission, discharge and transfer (ADT) - Appointments - Order entry and management - Clinical notes - Assessments - Care Plan - Condition specific documentation	- Medication and treatment records - Pharmacy information system - Lab information system - Therapy information system - Patient Portals - Patient eligibility determinations - Billing - Staffing, Payroll, and HR
Clinical Utility	- Patient Demographic, Health Information and Problem Lists - Clinical Decision Support - Physician Order Entry - Support Clinical Quality Measures	- Exchange health information (send, receive and integrate) - Privacy, Security and Integrity Features
Need for Information Exchange	High, as patients are discharged from acute care hospitals into these facilities as a result of serious injury, illness or surgery. Their clinical and medical information must travel with them to ensure adequate care.	
Barriers to Adoption	- Cost to adopt/lack of capital/lack of incentives - Lack of awareness of the need to implement an EHR - Lack of demand for an EHR - Lack of a certified vendor for provider specialty - Workforce limitations to implement and maintain an EHR	- Limited decision support for complex clinical condition - Lagging standards for clinical processes - EHRs available lack of alignment with MU criteria
a. Wolf, L., Harvell, J., and Jha, A. "Hospitals Ineligible For Federal Meaningful-Use Incentives Have Dismally Low Rates of Electronic Health Records." *Health Affair*, vol. 31 no. 3 (March 2012). http://content.healthaffairs.org/content/31/3/505.		

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2010 data (MedPAC, March 2012).

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"Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2012; Changes in Size and Square Footage of Inpatient Rehabilitation Units and Inpatient Psychiatric Units; Final Rule." 76 FR 47836 (August 5, 2011). http://www.gpo.gov/fdsys/pkg/FR-2011-08-05/pdf/2011-19516.pdf.

MedPAC. *Report to the Congress. Medicare Payment Policy*, March 2012.

Pennsylvania Health Care Cost Containment Council. *An Annual Report on the Financial Health of Pennsylvania's Non-GAC Facilities. Financial Analysis 2007 v.2: Ambulatory Surgery Center Care, Rehabilitation Care, Psychiatric Care, Long-term Acute Care, Specialty Care*. November 2008. http://www.phc4.org/reports/fin/07/docs/fin2007report_volumetwo.pdf.

Wolf, L., Harvell, J., and Jha, A. "Hospitals Ineligible For Federal Meaningful-Use Incentives Have Dismally Low Rates of Electronic Health Records." *Health Affair*, vol. 31 no. 3 (March 2012). http://content.healthaffairs.org/content/31/3/505.

C. Long-Term Care Hospitals

A long-term care hospital provides inpatient services, by or under the supervision of a physician, to patients whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital. The average inpatient length of stay is greater than 25 days. A long-term care hospital has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient progress, and consulting physicians on call and capable of being at the patient's side within a moderate period of time, and an interdisciplinary team.[5]

[5] Centers for Medicare and Medicaid Services. http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-p-4-a.

Long-Term Care Hospitals' Characteristics	
No. of providers	436[a]
Description	Long-term care hospitals treat medically complex patients who require hospital-level care for extended periods of time. These facilities are either freestanding or co-located with other hospitals as hospitals within hospitals or satellites.
Other names	Long-Term Care Hospital
No. of patients	118,300[b]
Description of patients	Patients treated in long-term acute care hospitals (LTACH) are typically medically complex, and require treatment for one or more serious conditions, such as life-threatening yet recoverable respiratory illnesses. About 65% of LTACH patients are Medicare beneficiaries.
Revenue	$8.0 Billion[a]
Owned by eligible provider	62% are freestanding; (38% hospital within hospital)[c] 60% are co-located with acute care hospitals, but under separate ownership.[d]
Medicare profit margin	6.4% overall[b]

a. 2011 data (MedPAC, June 2012).
b. MedPAC. *Report to the Congress. Medicare Payment Policy*, March 2012.
c. Grabowski, 2010.
d. CMS. Determining Medical Necessity and Appropriateness of Care for Medicare Long Term Care Hospitals, 2011.

Long-Term Care Hospitals Health IT Use, Clinical Utility and Barriers		
EHR Needed	Yes	
Adoption Rate	6%[a]	
Use in Practice	- Admission, discharge and transfer (ADT) - Appointments - Order entry and management - Clinical notes - Assessments - Care Plan - Condition specific documentation	- Medication and treatment records - Pharmacy information system - Lab information system - Therapy information system - Patient Portals - Patient eligibility determinations - Billing - Staffing, Payroll, and HR
Clinical Utility	- Patient Demographic, Health Information and Problem Lists - Clinical Decision Support - Physician Order Entry - Support Clinical Quality Measures	- Exchange health information (send, receive and integrate) - Privacy, Security and Integrity Features
Need for Information Exchange	High, as patients are admitted from a variety of settings, and may be transferred to one of several facilities for continuing or emergency care. Patients are medically-complex, with serious conditions that require complete knowledge of their medical history.	
Barriers to Adoption	- Cost to adopt/lack of capital/lack of incentives - Lack of awareness of the need to implement an EHR - Lack of a certified vendor for provider specialty - EHRs available lack of alignment with MU criteria	- Workforce limitations to implement and maintain an EHR - Limited decision support for complex clinical condition - Lagging standards for clinical processes

a. Wolf, L., Harvell, J., and Jha, A. "Hospitals Ineligible For Federal Meaningful-Use Incentives Have Dismally Low Rates of Electronic Health Records." *Health Affair*, vol. 31 no. 3 (March 2012). http://content.healthaffairs.org/content/31/3/505.

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D. Home Health Agencies

A home health agency provide skilled nursing and other therapeutic services such as physical therapy, occupational therapy, or speech-language pathology, medical social services, and home health aide services. Supervision of services is provided by a physician or a registered professional nurse.[6]

Home Health Agencies' Characteristics	
No. of providers	12,026 Medicare Certified[a]
Description	Home health agencies provide skilled nursing, therapy, aide, and medical social work services to beneficiaries in their homes.
Other names	N/A
No. of patients	3,400,000[a]
Description of patients	Home health patients require long-term part-time or intermittent skilled care to treat illness or injuries, and Medicaid Home Health services are a mandatory Medicaid benefit for enrollees entitled to nursing facility services. However, patients must also be unable to leave their home without considerable effort.
Revenue	$44.7 Billion[b]
Owned by eligible provider	10% (90% are freestanding)[c]
Medicare profit margin	In 2010, HHA margins in aggregate were 19.4% for freestanding agencies.[d]

a. National Association for Home Care and Hospice (NAHC). Basic Statistics about Home Care, Updated 2010. http://www.nahc.org/facts/10HC_Stats.pdf.
b. National Health Expenditures Accounts. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf.
c. MedPAC (March 2012).
d. MedPAC (March 2012). http://www.medpac.gov/chapters/Mar12_Ch08.pdf.

[6] Centers for Medicare and Medicaid Services. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf.

Home Health Agencies' Health IT Use, Clinical Utility and Barriers		
EHR Needed	Yes	
Adoption Rate	43%[a]	
Use in Practice	- Admission, discharge and transfer (ADT) - Appointments - Order entry and management - Clinical notes - Assessments - Care Plan - Condition specific documentation	- Medication and treatment records - Pharmacy information system - Lab information system - Therapy information system - Patient Portals - Patient eligibility determinations - Billing - Staffing, payroll, and HR
Clinical Utility	- Patient Demographic, Health Information and Problem Lists - Clinical Decision Support - Physician Order Entry	- Support Clinical Quality Measures - Exchange health information (send, receive and integrate) - Privacy, security and Integrity features
Need for Information Exchange	High, as patients are treated in their homes by several medical providers, but also require transfer to hospitals or nursing homes.	
Barriers to Adoption	- Cost to adopt/lack of capital/lack of incentives - Lack of awareness of the need to implement an EHR - Lack of a certified vendor for provider specialty - EHRs available lack of alignment with MU criteria	- Workforce limitations to implement and maintain an EHR - Limited decision support for complex clinical condition - Lagging standards for clinical processes
a. Resnick, H.E., Alwan, M. "Use of Health Information Technology in Home Health and Hospice Agencies: United States, 2007." *Journal of the American Medical Informatics Association (JAMIA)*, 2010, 17: 389-395. Abstract available online at: http://jamia.bmj.com/content/17/4/389.abstract.		

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MedPAC, June 2012.

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E. Hospice

A hospice organization provides care to terminally ill individuals under a written plan established and periodically reviewed by the individual's attending physician and by the medical director and the interdisciplinary team. The care and services described in subparagraphs may be provided on a 24-hour, continuous basis only during periods of crisis and as necessary to maintain the terminally ill individual at home. Services may be provided at an inpatient facility after meeting specific conditions.[7]

Hospice Characteristics	
No. of providers	5,150[a]
Description	Hospices provide care to terminally ill individuals, including therapy, nursing care, medical social services, physician care, or home health services.
Other names	Unknown
No. of patients	1,580,000 Medicare Hospice Patients[a]
Description of patients	Hospice patients are terminally-ill and require palliative and supportive care for these patients and their families. About 31% of Home Health patients suffer from cancer.
Revenue	$17.1 Billion[b]
Owned by eligible provider	21.3% are hospital-based[c]
Medicare profit margin	5.1%; dependent upon geography and/or ownership

a. NHPCO Facts and Figures: Hospice Care in America. Alexandria, VA: National Hospice and Palliative Care Organization, January 2012. http://www.nhpco.org/files/public/Statistics_Research/2011_Facts_Figures.pdf.
b. NAHC 2010 Data.
c. Grabowski, 2010.

[7] Social Security Act. http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm#act-1861-ii.

Hospice Health IT Use, Clinical Utility and Barriers		
EHR Needed	Yes	
Adoption Rate	43%[a]	
Use in Practice	- Admission, discharge and transfer (ADT) - Appointments - Order entry and management - Clinical notes - Assessments - Care Plan - Condition specific documentation	- Medication and treatment records - Pharmacy information system - Lab information system - Therapy information system - Patient Portals - Patient eligibility determinations - Billing - Staffing, Payroll, and HR
Clinical Utility	- Patient Demographic, Health Information and Problem Lists - Clinical Decision Support - Physician Order Entry - Support Clinical Quality Measures	- Exchange health information (send, receive and integrate) - Privacy, Security and Integrity Features
Need for Information Exchange	Low, as patients reside in hospices or receive hospice benefits for end-of-life treatment. Their conditions are terminal.	
Barriers to Adoption	- Cost to adopt/lack of capital/lack of incentives - Lack of awareness of the need to implement an EHR - Lack of a certified vendor for provider specialty - EHRs available lack of alignment with MU criteria	- Workforce limitations to implement and maintain an EHR - Limited decision support for complex clinical condition - Lagging standards for clinical processes
a. Resnick, H.E., Alwan, M. "Use of Health Information Technology in Home Health and Hospice Agencies: United States, 2007." *Journal of the American Medical Informatics Association (JAMIA)*, 2010, 17: 389-395. Abstract available online at: http://jamia.bmj.com/content/17/4/389.abstract.		

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Medicare Program; Hospice Wage Index for Fiscal Year 2012. Final Rule 76 FR 47327, http://www.gpo.gov/fdsys/pkg/FR-2011-08-04/pdf/2011-19488.pdf.

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F. Intermediate Care Facility for Persons with Intellectual Disabilities

Intermediate Care Facilities for persons with intellectual disabilities (ICF/IID) provide residential care services including comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. These facilities are available only for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services.[8]

Intermediate Care Facilities for Persons with Intellectual Disabilities Characteristics	
No. of providers	6,514[a]
Description	Intermediate Care Facilities for persons with intellectual disabilities provide health-related care and services above the level of custodial care to persons with mental retardation, but does not provide the level of care or treatment available in a hospital or skilled nursing facility. These facilities provide regular medical, nursing, social and rehabilitative services in addition to room and board for individuals incapable of independent living, typically from youth until old age.
Other names	ICF/MR, MR-DD Facility
No. of patients	87,560[b]
Description of patients	Patients are individuals with intellectual and developmental disabilities.
Revenue	$18.3 Billion[c]
Owned by eligible provider	Unable to determine.
Medicare profit margin	Unable to determine.

a. Larson, S.A., et al. *Residential Services for Persons with Developmental Disabilities: Statues and trends through 2010*. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration (2012). http://rtc.umn.edu/docs/risp2010.pdf.
b. Ibid.
c. U.S. Census Bureau, 2007 Economic Census. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

[8] Medicaid.gov. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Intermediate-Care-Facilities-for-Individuals-with-Mental-Retardation-ICFMR.htm.

Intermediate Care Facilities for Persons with Intellectual Disabilities Health IT Use, Clinical Utility and Barriers		
EHR Needed	Yes; dependent upon size	
Adoption Rate	Unknown	
Use in Practice	- Admission, discharge and transfer (ADT) - Appointments - Order entry and management - Clinical notes - Assessments - Care Plan	- Condition specific documentation - Medication and treatment records - Pharmacy information system - Therapy information system - Patient eligibility determinations - Billing - Staffing, Payroll, and HR
Clinical Utility	- Patient Demographic, Health Information and Problem Lists - Clinical Decision Support - Physician Order Entry - Support Clinical Quality Measures	- Exchange health information (send, receive and integrate) - Privacy, Security and Integrity Features
Need for Information Exchange	High, as patients require transfer and discharge to-and-from skilled nursing facilities or acute care hospitals for treatment above basic nursing care.	
Barriers to Adoption	- Cost to adopt/lack of capital/lack of incentives - Lack of a certified vendor for provider specialty - EHRs available lack of alignment with MU criteria	- Workforce limitations to implement and maintain an EHR - Limited decision support for complex clinical condition - Lagging standards for clinical processes

ICF/IID References

American Health Care Association. *LTC Stats: Intermediate Care Facilities for Individuals with Mental Retardation/Developmental Disabilities*. October 2011 Update. http://www.ahcancal.org/research_data/oscar_data/Intermediate%20Care%20Facilities%20MRDD%20Survey%20Reports/MRDDLTCSTATSSummaryReport.pdf.

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Braddock, D., et al. *The State of the States in Developmental Disabilities*, 2011. http://www.stateofthestates.org/documents/SOS%20FINAL%20REVISED%20EDITION2011.pdf.

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Henry J. Kaiser Family Foundation. "Distribution of Medicaid Spending on Long Term Care, FY2010."

Highbeam Business. http://business.highbeam.com/industry-reports/business/intermediate-care-facilities.

Table 8.E1--Number of recipients, total vendor payments, and average payment, by type of medical service, fiscal years 1985-2009. *Annual Statistical Supplement to the Social Security Bulletin*, 2011, p.446.

U.S. Census Bureau, 2007 Economic Census. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

United States Public I/DD Spending by Revenue Source: FY 2009. http://www.stateofthestates.org/documents/UnitedStates.pdf.

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