APPENDIX R. TECHNICAL ADVISORY GROUP SUMMARY

This appendix provides a summary of the Technical Advisory Group (TAG) meeting held at HHS on June 13, 2012. The TAG meeting brought together experts to provide feedback and input to advise the contractor (the AHIMA Foundation) on ineligible providers and incentive/funding considerations. The information from the TAG was used in the development of a final report to ASPE to support preparation of the report required by 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). The TAG's specific role was to perform the following:

- Provide feedback on the:
  - identification and categorization of providers ineligible for incentives/other funding of use of EHRs; and
  - completeness/accuracy of identified EHR incentives/funding options.

- Consider whether current incentives/other funding to support the use of certified EHRs will be sufficient to:
  - achieve the goals of the EHR Incentive Programs for Eligible Professionals/Eligible Hospitals;
  - support the use of certified EHRs/health IT by all/some of the ineligible providers; and
  - if the current support is sufficient, why and how; and if not, why not.

- Identify factors that should be considered when examining the costs of making available at least some incentives/ funding options for certain ineligible providers.

- Identify barriers to implementing incentives/other options and methods to address identified barriers.

Summary: The TAG focused on the following key themes throughout the meeting:

- Establish goals for what is to be achieved with the availability of additional incentives and/or other funding for ineligible providers. These goals should be:
  - Focused on the patient and support the Center for Medicare and Medicaid Innovation (CMMI) Triple Aim.
  - Future-looking to support new healthcare delivery and payment models.
  - Supportive of meaningful use by eligible hospitals and eligible professionals.

- Do not apply a one-size-fits-all approach to incentive and/or other funding programs targeted at ineligible providers. Programs should be prioritized for

targeted providers and custom fit to help the providers overcome barriers in achieving the desired goal.

- Prioritize the LTPAC and Behavioral Health ineligible providers for incentives and/or other funding.

- Do not limit programs to just EHR technology. Application and modules may be appropriate to facilitate interoperable health information exchange.

TAG Feedback on Ineligible Providers

The TAG reviewed the methodology for selecting the ineligible providers to be the focus of the study and final report (Figure R1 outlines the methodology used). The TAG agreed with the methodology used to identify and select the ineligible providers focusing on providers who are identified in HITECH §3000(3), grouping the providers into two categories -- those eligible for payment incentives under HITECH and those who are ineligible, and selecting the ineligible providers who participate in the Medicare and Medicaid programs.

The TAG reviewed and provided feedback on the providers who were identified as ineligible for payment incentives under HITECH. Based on the methodology used to identify the ineligible providers, not all providers in the United States health care system will be the focus of this study. The TAG noted that there are health care provider organizations (facility/place), professionals/ practitioners (people), and health care service programs. To remain consistent with the HITECH, healthcare services (such as home and community-based services) are not included in this study.

Other TAG recommendations:

- Correctional Facilities, Jails, and Prisons are not identified as providers in HITECH or eligible for Medicare and/or Medicaid, however, the TAG discussed the importance of having health information available and exchanged particularly when inmates leave the prison system and require continued treatment and services for medical and/or behavioral health conditions.

- Some of the ineligible providers may have access to certified EHR technology through their affiliation with an eligible hospital or eligible professional.
  - Reevaluate Ambulatory Surgery Centers on the ineligible provider list. Their eligibility may be an issue of affiliation or ownership (i.e., hospital-based).

- Recognize that the ancillary providers identified in the **Other Healthcare Provider section** may not use EHR, but may merely require an interface (as discussed above for labs, pharmacies, blood banks, and ambulance services). Reconsider these providers on the ineligible provider list because they are a service organization and do not maintain an EHR. They provide valuable

information and must have the capability to exchange information with an EHR. The TAG suggested a footnote in the main report that expresses the importance of these providers to interoperability exchange of health information.

Current Environment and Drivers for EHR Technology Adoption

The TAG discussed the current environment and drivers for adoption. As part of that discussion, they reviewed and commented on the proposed evaluation criteria definitions below and identified additional evaluation criteria.

The TAG recommended that the final report define a goal to be met with incentives or other funding that supports a provider's interoperability to benefit the patient and CMMI Triple Aim: better health in the overall population, better health care delivery, and reduction in per capita cost of care. The goal would serve as a point of focus for evaluation criteria on how the technology supports the interoperability and the CMMI Triple Aim.

The TAG identified three important factors in evaluating the use of EHRs/health IT by ineligible providers. The major difference from the proposed criteria is to differentiate between use and utility on how it benefits the provider and how it benefits the patient/society to improve care.

FIGURE R1. TAG Priorities for Evaluation Criteria

Level of Technology Adoption	Benefit of Technology to the Provider	Benefit of Technology to the Patient and to Improve Patient Care
- Denominator for each sector is crucial to understand adoption rates when being used for incentives - Determine adoption rates for the subset of providers that receive Medicare and Medicaid	- How provides use technology to benefit their business - Agreed with prioritizing meaningful use criteria but recognized that it may not apply to all ineligible providers	- Prioritize technology and functionality that will benefit the patient - Improves care for the patient - Improves the value of care (cost & efficiency) - Addresses re-hospitalizations - Addresses societal needs

TAG Discussion on Adoption Rates of EHR Technology by Ineligible Providers

The TAG did not support limiting the measurement of EHR adoption rates to certified EHR technology (CEHRT) because the definitions do not apply to the ineligible providers. They recognized that adoption statistics for EHR technology are an important factor when determining incentive or funding options, however, concerns were raised about the ability to measure adoption in a consistent manner against national

averages.[1] While ONC reports EHR adoption statistics for eligible hospitals and professionals on their dashboard,[2] standardized definitions and surveys are not in place for ineligible providers except Federally Qualified Health Centers. HRSA collects EHR data from Centers from the Uniform Data Systems administrative dataset.

TAG Discussion on Clinical Utility of EHR Technology by Ineligible Providers

The TAG viewed clinical utility differently than the proposed definition which focused on how the technology supported the provider's clinical and business operations. They recommend that clinical utility be framed from the patient's perspective -- how technology supports patient care, coordination, and transitions. The TAG recommended that clinical utility be defined as how the EHR technology directly enables the provider's ability to deliver efficient and effective patient care. Considerations include:

- How is patient care affected by technology?
- Will having this technology improve care?
- Will some providers have a greater need for technology to share information than others? For example, some consideration highlighted by the TAG include:
  - Patients who have high re-admission rates;
  - Providers who serve patients with multiple, chronic conditions and require multiple care givers to share and coordinate care; and/or
  - Providers who support patients who are a lifetime residents and require frequent interaction with the continuum of care (such as providers serving the developmentally disabled).

The TAG noted that the clinical utility of an EHR may be greater for providers who serve patients with numerous transitions and/or re-hospitalizations. There is a similar direct relationship between clinical utility and providers serving lifetime patients where there are frequent care coordination needs with multiple specialists.

TAG Discussion on Use of Technology by ineligible Providers

The TAG supported the use of a technology definition focused on meaningful use stage criteria. They agreed that some providers had a greater need to use technology.

[1] Adoption estimates should be interpreted with caution due to "significant variability in breadth and depth of survey content, data item construction, terminology, and definitions (when definitions are provided at all), as well as issues of sample size and representativeness." http://aspe.hhs.gov/daltcp/reports/2009/HITlitrev.htm#assess.

[2] See http://dashboard.healthit.gov/HITAdoption/.

The TAG also noted that not all ineligible providers would benefit from EHRs or incentives for EHRs, specifically:

- Ancillary service providers (such as labs or pharmacies) need technology that facilitates interoperability and communication with providers' EHR system. These ancillary providers may need a module or application to exchange interoperable health information rather than adopt a complete EHR.

- Emergency Service/Ambulance Providers could benefit from interoperable systems, particularly viewing information on a patient and transmitting data to a provider's EHR. A module or application that allows viewing and sharing common information would be beneficial.

Other Evaluation Criteria Identified by the TAG

The TAG discussed other criteria that could be useful to evaluate the need for EHR incentives and/or other funding. The following summarizes the criteria and points of consideration.

Ability to Survive Market Forces

Incentive and/or other funding should only be available to providers who will survive market changes. Questions to consider include: Which providers will still be delivering services in 2014 and beyond? Where will there be consolidation? Will the provider be able to survive without incentives? Will they meet the changing demands of the healthcare delivery and payment system on their own? Some providers will not need incentives or other funding to adopt interoperable technology because business forces will push adoption. For example, a pharmacy serving large providers in urban areas may invest in health IT for business reasons to facilitate interoperable communication but a small pharmacy or lab in rural areas may need support to implement interoperable technology.

Benefit to Medicare and Medicaid (Expenditures/Costs)

Incentives and/or other funding should benefit Medicare and Medicaid. Who bears the cost and who gets the benefit from EHR technology (EHRT)? Where is there cost savings? What are the Medicare and Medicaid expenditures by the provider? Are there opportunities to reduce costs and improve quality through the use of CEHRT? Would the technology allow Medicare and Medicaid move toward risk adjusted and pay for performance models? The costs per treating a patient (per year/per episode) may also be a relevant factor in prioritizing providers for incentives.

Capacity to Invest (Margins)

The extent to which provider payments exceed costs (i.e., margins) should be taken into account in determining a provider's ability to invest in technology on their own without incentives and/or other funding. What are the margins for the ineligible providers? For some provider types Medicare margins may be high (e.g., home health) and in some instances margins may vary for subcategories of particular provider types (e.g., rural vs. urban). In contrast, Medicaid margins are believed to be lower. Providers (e.g., Medicaid-reliant providers) with lower margins may need to rely on grants for funding and other means to support the costs of acquisition and/or use of technology. Margin data can be found in Medicare Payment Advisory Commission reports and Medicare and Medicaid cost summary reports. Some ancillary providers have margins that far exceed standard health care providers (e.g., CVS pharmacies) and should not be the target for incentives and/or funding.

Market Size/Capacity

Information on the number of the providers or professionals in the market and number of patients treated could be important in prioritizing the providers and the impact incentives and/or other funding may have on the largest number of patients.

Need for Exchange Now and with Future Business Models

In order for exchange to be meaningful, some providers may be more involved in transitions on care in current and future service delivery models. To what extent is exchange necessary between health providers to improve transitions now? Which providers are important to new delivery models such as ACOs to improve care? Which providers are important to a state to monitor public health?

Support for Current EHR Incentive Programs

Providers could be prioritized for incentives and/or other funding based on their importance to eligible hospitals and professionals to meet their meaningful use criteria. Do the ineligible providers assist eligible providers in meeting meaningful use requirements? Will incentivizing CEHRT for the ineligible provider improve care across the continuum?

Relationship to Eligible Organization

Some providers and professionals may be ineligible, but work for or are part of an eligible hospital or professional organization with access to CEHRT. Is there a way to determine how many are free-standing or not-associated with an eligible hospital/professional? If there are minimal free-standing providers, there may not be a reason to prioritize them for possible incentive or other funding.

Geography

The location of an ineligible provider may be an important factor in determining whether to extend incentives and/or other funding particularly if they are a safety net provider or in rural or underserved areas. Margins are also impacted by geography.

Availability of Other Funding to Adopt & Use EHRs

Some ineligible providers have access to other funding sources and grants to support adoption and use of technology minimizing the need to extend other programs or incentives. Are there other funding sources beside EHR Incentive Program incentives to assist in the adoption and use of CEHRT? For example, Safety Net providers have grant funding available to adopt technology and other funding has been directed to these providers to support their use of this technology. The availability of funds to support the acquisition and use of EHRT may not make these providers a priority to receive additional incentives.

Provider Track Record

Incentive and/or other funding programs should not be offered to providers where there are serious fraud concerns. Do the providers have a good record as a Medicare provider? Is there any litigation against them? The TAG members expressed concerns about some providers such as home care where there are fraud rings in Florida. Programs should be designed to ensure only legitimate providers are assisted.

Summary of Evaluation Criteria/Principles

- The need for technology that supports future care delivery, business models, and providers.
- The need for technology to support care coordination and management, and health information exchange.
- Information known about adoption costs to acquire and maintain the technology.
- Cost of the incentive.
- The benefit of technology to improve care delivery and outcomes for the patient.
- The provider's benefit and their need for EHRs that supports best practices and outcomes for their patient.
- The ineligible provider's ability to access capital and/or cover the cost of technology based on their profit margin.

- The benefit to Medicare and Medicaid of incenting technology that supports:
  - Quality and financial oversight.
  - Data for risk adjustments and pay for performance.

- The benefit to society (public health/population health).

General TAG Recommendations on the Need for Incentives

Interventions Should Have the Future in Mind

The TAG recommended that the final report look at the future (2014 and later) and emerging business models. Health care is moving towards new delivery and payment models with health care reform. The report should look at the future and identify the ineligible providers who will survive the transition or be priority providers that need interoperable technologies.

Interventions Need to Be Patient Centered

If actions are undertaken, they must support a patient-centered approach to care delivery.

Interventions Should Support Meaningful Use

Any actions/interventions for ineligible providers should focus on meaningful use and help eligible hospitals and professionals meet the program priorities.

There Should Not Be a "One-Size-Fits-All" Approach to Incentives and Other Funding for Ineligible Providers

The TAG agreed that broadly applying the EHR Incentive Programs to all of the ineligible providers is not necessary. They recognized that the ineligible providers would have different needs or barriers to overcome and some are adopting the technology more successfully than others and would not require the same level of support. The TAG recommended an approach that identified specific goals and used different interventions to meet the goals. They outlined general categories.

Overview of Levels of Support

The TAG discussed the concept of levels of support to tailor interventions to the needs of the ineligible provider in meeting goals.

- Level 1 -- No Assistance: The market will naturally evolve and do it anyway
- Level 2 -- Mandate the implementation of technology using federal and state authority (e.g., through regulatory requirements)

- Level 3 -- Provide direct support (e.g., grants, loan programs)
- Level 4 -- Provide indirect support (e.g., technical assistance/consulting services)
- Level 5 -- Provide financial incentives (e.g., extend EHR incentive programs)

Barriers to Ineligible Provider EHR Technology Adoption

To determine what interventions (incentives/other funding) or level of support may be necessary, the TAG summarized their perception of the current barriers to adoption by ineligible providers. The following is a general list of barriers. To tailor interventions, the goals and barriers would need to be identified for each ineligible provider type.

1. Lack of standards across continuum of care.
2. Lag time in vendor's adoption of standards.
3. Lack of clear clinical/economic reason for stand-alone facilities to adopt CEHRT (No business case).
4. Workforce issues -- not trained on health IT/EHR technology and/or small in size particularly in health IT to operate EHR systems and infrastructure.
5. Confusion over what technology to adopt.
6. Current workflow set; do not want to adopt technology.
7. Lack of access to capital markets.
8. Lack of free capital (thin margins, as in the case of many Medicaid providers).
9. Perceived privacy concerns and the technological barrier 42 CFR presents particularly with behavioral health settings providing substance abuse services.
10. Individual provider lacks infrastructure/knowledge to win grants and other funding.

Program that Could Apply to All/Almost All Ineligible Providers

The TAG identified the following set of funding or other programs that could be applied to all/almost all ineligible providers at a relatively low cost:

- Anti-Kickback Statute EHR Safe Harbor Regulation
- Deployment of broadband internet everywhere
- ONC Direct Project
- Leverage federal Conditions of Participation to require certain EHR/health IT capabilities
- Grant requirements that include conditions on key EHR/health IT capabilities
- Current infrastructure opportunities in programs such as Medicaid grant opportunities, technical assistance to states on health IT, etc.

Framework for Evaluating Actions per Ineligible Provider

After considerable discussion, the TAG recommended that each ineligible provider type be evaluated for a course of action. They identified evaluation questions and three general actions as outlined below.

- **Why** is the EHR/health IT important to support national goals? Why is it important to patients, providers, emerging business models, and current meaningful use provider?

- **What** is known about the provider, their use of EHRs, the availability of interoperable health IT, their barriers and the desired outcomes?

- **How** will the use of technology support the desired outcome?

- What **program action** should be considered?

    1. **Ignore**: Due to the current financial status and prevalence of grants or other funding, no further incentive/funding action should be directed to the provider.
    2. **Encourage**: Use carrots and sticks to encourage desired action. Carrots could include the EHR Incentive Program, pay for performance programs, positive payment rate adjustments, low interest loan, grants, and other interventions. Sticks include implementing negative payment rate adjustment or other penalties for not adopting/using interoperable EHR technology.
    3. **Mandate**: Drive the desired action by creating an administrative requirement (e.g., Condition of Participation) to earn Medicare/Medicaid funding or fees, or program participation.

Sample Application of the Framework

The TAG applied the framework to three provider settings: Home Health Agencies; Community Mental Health Clinic; and Federally Qualified Health Clinic. The framework was an exercise to demonstrate a process and not to be considered a formal recommendation by the TAG. The information used in the exercise may or may not be accurate and was based on TAG member knowledge or perceptions rather than researched facts.

Home Health Agency

Why is EHR technology important?

The population served by home health agencies experiences multiple transitions and has complex clinical needs. As a result, home health is a prime candidate for

health IT support. Areas of potential support include remote monitoring and support to achieve an interoperable technology infrastructure needed for health delivery reform such as new ACO delivery and payment models. Improving communication and information sharing is critical with transitions of care and re-hospitalization issues. For the home care provider EHRs support improved patient management and communication. Clinical decision support and other technology supports would be beneficial for skilled nursing/therapy services such as wound care. Technology also improves internal communications between care givers and nurses/therapists.

What do we know about the provider and their use of technology?

There are EHR vendors for home health agencies, but they have not yet deployed interoperability standards that allow exchange with eligible hospitals and professionals to support the EHR Incentive Programs.

Adoption Status: Adoption of EHRs is at 39 percent. The sector is starting to adopt EHR technology on their own, although a business case to invest in interoperable technologies has not emerged. Over time the economic/clinical reasons for the agency to adopt technology may change with healthcare reform to ensure referral sources from eligible hospitals and professionals.

Home health vendors may be challenged to keep up with the demand for multiple interfaces as every HIE organization requires a custom interface which is expensive custom programming. The sector lacks interoperable standards and technology to exchange basic information such as summary records. It is not clear which interoperability standards apply to home health agencies.

Barriers: Connectivity in the home is still an issue in some regions due to limited broadband availability, however connectivity is becoming increasingly available.

Other general barriers apply to home health, particularly related to workforce as many organizations don't employ staff with expertise in EHR technology.

Program Actions: Encourage plus mandate

1. Combine a mandate with a carrot: Require the use of interoperable technologies through the Home Health Care federal Conditions of Participation (stick) in combination with a carrot. MedPAC discussed having standards for the home health benefit. Until standards and formats are available, it is difficult to move forward.

2. Encourage (Carrots/Sticks): Could make available various approaches based on size and sophistication:
    a. Adjust Payment -- "rate minus" if an agency does not implement technology or "rate plus" if they do. Require certain capabilities.

b. Low interest loans for agencies with lower capital or less access to capital markets.
c. Grants to acquire technology targeted to Medicaid providers.

3. Disseminate information on the applicability of the Anti-kickback Safe Harbor Statute to home health care providers.

4. Extend technical assistance (TA) and workforce training programs to certain types of home health agencies (such as TA through Regional Extension Center services).

The TAG indicated the home health analysis could also be applied to long-term care facilities (SNF/NF) because there are similar characteristics.

Community Mental Health Clinic (CMHC)

Why is EHR technology important?

The National Council for Behavioral Health just released a survey on health IT use which showed that the severely mentally ill have numerous health conditions and problems not limited to behavioral health. They are complex patients, frequently have housing issues, and often have substance abuse issues. These patients are expensive and are often described as accessing health care services through a "revolving door".

The Community Mental Health Center is frequently the patient's primary contact with the health system, but often has poor connections with the primary medical care system. They could be considered the safety net provider for many Medicaid behavioral health patients. Case management/care coordination is very important to improving quality of care, care delivery, and efficiency.

The lack of interoperable technology by community mental health clinics solidifies the silos between behavioral health care and primary care for medical conditions. Coordination and communication between primary care and CMHC is critical particularly with medication coordination and reconciliation.

Health care reform brings new models including health homes which will provide the case management/care coordination needed, however, CMHCs will need the technical infrastructure to actively participate in the emerging health home models.

What do we know about the provider and their use of technology?

The adoption of EHRs by CMHC is low. Psychiatrists are eligible for EHR incentive payments, but many have their own practice and will use EHR Incentive Program payments for their own EHR acquisition rather than reassigning the payment to the CMHC.

The primary payer for CMHCs is Medicaid with some funding through Medicare and private grants. The typical patient with schizophrenia costs Medicaid approximately $18K per year. Generally CMHCs have very limited resources to invest in technology and no profit margins. The TAG recognized that they needed more information on the market size and costs of the population.

Barriers include a lack of resources (including workforce) to invest in both EHR and interoperable technology. There are privacy and consent concerns with interoperability that are yet to be addressed with a standards-based technical infrastructure. Many state HIE organizations are not investing in exchange use cases to support behavioral health providers due to the lack of standards to address the complex privacy and consent issues.

Program Actions: Encourage

- Extend a modified EHR Incentive Programs (potentially through grants with similar features to meaningful use) to CMHCs which would include:
  - Funding to support the acquisition and use of CEHRT.
  - Development of national standards to address privacy and consent issues (which would benefit all of health care).
  - Technical assistance to implement CEHRT (e.g., RECs).

- Grant programs/funding options with Health Homes:
  - Grants to support infrastructure development and standards.
  - The TAG recognized that additional analysis was needed evaluate opportunities with the health home Medicaid state plan amendment and whether there was funding available that could be used as an incentive or grant for CMHCs.

Federally Qualified Health Center (FQHC)

The TAG began to analyze FQHCs and noted the following facts:

- FQHCs have received a fair amount of HIT grant funding from HRSA. Some eligible professionals may assign their benefits to the health center (although the data on how many do so is limited).

- EHR Adoption rate is higher than other ineligible providers.

- FQHCs have a Medicaid cost based system that is more generous than other providers.

- Medicare has a higher reimbursement for FQHCs than other providers.

For these reasons, the TAG recommended no additional incentive action for FQHCs is needed.

TAG Members

The TAG was comprised of individuals from both the private sector and Federal Government. Individuals were invited and selected who had expertise on health care policy and payment methodologies, specific ineligible provider types, health care economics, and health IT/EHR use, incentives and funding programs. The following individuals comprised the Technical Advisory Group for the "Study and Report on Application of EHRs and Payment Incentives for Providers Not Receiving Other Incentive Payments:"

John Allison, Acting Technical Director, CMS in the Center for Medicaid and CHIP Services

Maureen Boyle, Ph.D., Lead Public Health Advisor and the Team Lead for Health Information Technology at the Substance Abuse and Mental Health Services Administration (SAMHSA)

Richard G. Frank, Ph.D., Margaret T. Morris Professor of Health Economics in the Department of Health Care Policy at Harvard Medical School.

Marsha Gold, Ph.D., Senior Fellow, Mathematica in Washington, DC.

Jennie Harvell, Project Officer; Senior Policy Analyst, HHS in the Office of the Assistant Secretary for Planning and Evaluation

Lorin Hitt, Ph.D., Professor of Operations and Information Management at the University of Pennsylvania, Wharton School

Warren Jones, M.D., FAAFP, Executive Director of the Mississippi Institute for Improvement of Geographic and Minority Health Disparities

Ruth E. Katz, Associate Deputy Assistant Secretary for the Office of Disability, Aging and Long-Term Care Policy, HHS in the Office of the Assistant Secretary for Planning and Evaluation

Peter Kemper, Deputy Assistant Secretary for Disability, Aging, and Long-Term Care Policy, HHS in the Office of the Assistant Secretary for Planning and Evaluation

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Rachel Maisler, Health Insurance Specialist, Centers for Medicare and Medicaid Services in the Office of e-Health Standards and Services

Michael Millenson, President, Health Quality Advisors, LLC

Judy Murphy, RN, FACMI, FHIMSS, FAAN, Deputy National Coordinator for Programs and Policy Office of the National Coordinator for Health IT, HHS

Michael Pepper, Analyst, HHS in the Office of the Assistant Secretary for Planning and Evaluation

William Rudman, PhD, RHIA, Executive Director, AHIMA Foundation

Michelle Dougherty, MA, RHIA, CHP, Director of Research, AHIMA Foundation

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

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APPENDIX C. Public Health Service Act Section 3000(3) as Added by HITECH Section 13101 -- Provider Analysis
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APPENDIX N. Administrative Infrastructure Building Programs
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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