



Center for Medicaid, CHIP and Survey & Certification

SMDL# 11-002
ARRA# 8

April 8, 2011

**Re: Technical changes impacting the Medicaid
EHR Incentive Program from the 2010 Medicare
and Medicaid Extenders Act**

Dear State Medicaid Director:

This letter provides guidance to State Medicaid agencies regarding technical changes in section 4201 of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Pub. L. 111-5, as a result of section 205(e) of the Medicare and Medicaid Extenders Act of 2010 (the Extenders Act), Pub. L. 111-309. The Extenders Act, enacted on December 15, 2010, amended sections 1903(t)(3)(E) and 1903(t)(6)(B) of the Social Security Act (the Act). The amended sections change the requirements for an Eligible Professional (EP) to demonstrate the “net average allowable costs,” the contributions from other sources, and the 15 percent provider contribution to participate in the Medicaid Electronic Health Record (EHR) Incentive Payment Program. The Extenders Act now provides that an EP has met this responsibility, as long as the incentive payment is not in excess of 85 percent of the net average allowable cost (\$21,250 for first year payments).

Summary

Prior to the Extenders Act, Medicaid EPs who wanted to participate in the EHR Incentive Payment Program were required to provide documentation of certain costs related to acquiring and implementing certified EHR technology. The Extenders Act amended the Medicaid EHR Incentive Program by allowing for providers to simply document and attest that they have adopted, implemented, upgraded, or meaningfully used certified EHR technology, while allowing the Centers for Medicare & Medicaid Services (CMS) to set these average costs.

Background

The documentation originally required by an EP for demonstrating the “net average allowable costs,” and the contribution amounts from other sources, is no longer required as the Extenders Act allows CMS to establish the average payment that Medicaid EPs will receive from other (non-governmental) sources. As a result, rather than requiring each EP to calculate the payments received from outside sources, each will use the average costs and contribution amount established by CMS. After conducting a meta-analysis of existing data of an EP’s costs to adopt, implement, or upgrade certified EHR technology, CMS has determined that average contributions from outside sources should not exceed \$29,000.

The documentation originally required by an EP to demonstrate that he or she contributed 15 percent (e.g., \$3,750 for Year 1) of the “net average allowable costs” is also no longer needed. The Extenders Act now provides that an EP has met this responsibility as long as the incentive payment is not in excess of 85 percent of the net average allowable cost (\$21,250).

Calculations

As shown in the table below, in rulemaking, CMS determined the average allowable cost to acquire certified EHR technology and implementation support for the purposes of this program to be \$54,000. The statute – as amended by the Extenders Act – requires the agency to reduce net average allowable costs by *average* contributions from certain outside sources. In addition, the statute, as originally enacted, requires that in no case will net average allowable costs exceed \$25,000 in Year 1 (or \$10,000 in subsequent years). Thus, to reach the statutory maximum of \$25,000 for net average allowable costs in Year 1, the average contribution from outside sources cannot exceed \$29,000. As we have determined that average contributions are less than \$29,000, the “net average allowable cost” for this program remains at the statutory maximum of \$25,000 per EP for the first payment year.

Also, as long as the State can verify that no more than 85 percent of the net average allowable cost was paid to the EP as an incentive payment, an EP is determined to have met the remaining 15 percent of the cost under section 1903(t)(6)(B) of the Act. Additionally, all EPs are deemed to have met the requirement that no more than \$29,000 be received in contributions from other (non-governmental) sources.

Determination of Net Average Allowable Costs for the First Payment Year

<u>First Year Variables¹</u>	<u>Amounts</u>	<u>Prior to Extenders Act Changes</u>	<u>Currently</u>
Average Allowable Costs	\$54,000	Determined through a CMS meta-analysis, described in both the Notice of Proposed Rulemaking (75 Fed. Reg. 1844) and the Final Rule (75 Fed. Reg. 44314).	No change.
Contributions from Other Sources	Does not exceed \$29,000	Subtracted from Average Allowable Costs to reach “Net” Average Allowable Costs. An EP was required to show documentation of all contributions from certain other sources.	No documentation is needed. We have determined that average contributions do not exceed \$29,000.
Capped Amount of “Net” Average Allowable Costs	\$25,000	Capped by statute and designated in CMS Final Rule.	No change.

¹ These same concepts (but not figures) apply to the second through sixth years, integrating the figures from the Final Rule. Ultimately, the incentive paid in the second through sixth years is still the statutory maximum of \$8,500.

<u>First Year Variables</u>	<u>Amounts</u>	<u>Prior to Extenders Act Changes</u>	<u>Currently</u>
Contribution from the EP	\$3,750	An EP was required to demonstrate that he or she had contributed at least 15 percent of the net average allowable costs towards a certified EHR.	No documentation needed. Determined to have been met by virtue of EP receiving no more than \$21,250 in the first payment year.
Incentive payment ²	\$21,250	85 percent of the Net Average Allowable Costs; determined through statute. An EP could receive less than this amount if he or she had contributions from other sources exceeding \$29,000.	All EPs will receive the maximum incentive payment of \$21,250, as all EPs will be determined to have contributions from other sources under \$29,000.

Please contact Mr. Rick Friedman, Director, Division of State Systems, of my staff, at 410-786-4451, or Richard.Friedman@cms.hhs.gov, if you have any questions.

Sincerely,

/s/

Cindy Mann

² This figure is further reduced to two-thirds for pediatricians qualifying with reduced Medicaid patient volumes. This is described at 42 CFR 495.310.

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Matt Salo
Executive Director
National Association of Medicaid Directors

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Director of Health Legislation
National Governors Association

Rick Fenton
Acting Director
Health Services Division
American Public Human Services Association

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Debra Miller
Director for Health Policy
Council of State Governments

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy