DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid, CHIP and Survey & Certification

SMDL# 11-004
ARRA# 9

May 18, 2011

Re: Use of administrative funds to support health information exchange as part of the Medicaid EHR Incentive Program

Dear State Medicaid Director:

This letter provides further guidance to State Medicaid agencies regarding the implementation of section 4201 of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Pub. L. 111-5 and regulations at 42 Code of Federal Regulations (CFR) Part 495, Subpart D. Division B, Title IV, Subtitles A and B of the Recovery Act established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, as one component of the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH, as well as our final regulation, governs incentive payments to eligible professionals (EPs) and eligible hospitals to promote the adoption and meaningful use of certified EHR technology.

The Recovery Act provides 100 percent Federal financial participation (FFP) to States for incentive payments to eligible Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology through 2021, and 90 percent FFP for State administrative expenses related to the program. These administrative matching funds must be for activities that are proper and efficient (as defined by OMB Circular A-87) for the administration of the Medicaid EHR Incentive Program.

The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director (SMD) letter on August 17, 2010 that provided guidance to States on allowable expenses for activities supporting the administration of the Medicaid EHR Incentive Program. The letter outlined CMS expectations of activities and potential eligible costs for the 90 percent FFP for administration and oversight of the EHR incentive payments. In addition, that letter provided initial direction regarding State Medicaid agencies' role in promoting EHR adoption and health information exchanges (HIE). This letter provides more detailed guidance on the State expenditures related to the development and sustaining of HIE(s) that may be eligible for the 90 percent FFP.

Background

As defined in our July 28, 2010 final regulations, Stage 1 of "meaningful use" includes several objectives related to the electronic exchange of health information. Anticipating that State Medicaid agencies would have a role in promoting EHR adoption and HIE, CMS identified ten

Guiding Principles for the 90 percent FFP funds for those activities in the August 2010 SMD letter. Please refer to that letter and Enclosure C of that letter for more detail, as this SMD letter focuses on a subset of those principles. States are reminded that the first core principle applied to use of the 90 percent HITECH FFP is that the activities can be directly correlated to the Medicaid EHR Incentive Program.

Specifically, this SMD letter provides further detail on our criteria that health information exchange promotion activities: 1) have costs that are divided equitably across other payers (e.g., private/commercial) based on the fair share principle (defined in OMB Circular A-87 as "in accordance with benefits received") and are appropriately allocated, 2) leverage efficiencies with other Federal HIE funding, and 3) are developmental and time-limited in nature. This letter also reiterates the principle that the 90 percent FFP would not be available for on-going HIE costs where these services are fully operational.

As we have stated previously, HIEs are a necessary ingredient to meaningful use of EHRs and to the success of delivery system reform efforts. This letter outlines the circumstances in which we believe States can use enhanced administrative FFP to join or spearhead efforts to build this needed infrastructure.

Other Payer Participation/Fair Share Principle

The August 2010 SMD letter noted that States should consider Medicaid's contribution to HIE in view of contributions by other payers. Funding from Medicaid should be part of an overall financial plan that leverages multiple funding sources to develop and maintain HIEs between hospitals, health systems and individual practices.

Various Federal and State funding, as well as contributions by commercial payers, large employers, integrated delivery networks, associated entities such as laboratories, registries and provider user fees may be necessary to share the costs of building and maintaining HIEs. There are several rationales for entering into HIE infrastructure development activities via public/private partnerships. First, the efficiencies and quality improvements associated with electronic health information exchange accrue to all participants; e.g., other payers, integrated delivery networks, Accountable Care Organizations, medical and health home networks, hospital systems, etc. Likewise, the governance and risks associated with developing HIE infrastructure, such as seeking provider buy-in and determining effective pricing strategies, should not be borne solely (or predominately) by a single payer. Lastly, each State's HIE assets and challenges are different, and HIE strategies need to be developed with broad stakeholder involvement to ensure that the marketplace is balanced to support both the public and private health systems' business cases.

States should leverage their Medicaid investment with investments by a sufficient number of other payers and stakeholders to establish a sustainable business model. States have asked CMS to determine the degree of other payer contribution that is needed to meet this principle for approval of administrative funding. While Medicaid may serve as a catalyst to establish an HIE infrastructure, additional partners must be drawn into the marketplace based upon their share of the allocated costs. Medicaid funding cannot be the sole funding source for building,

implementing or operating HIE entities and/or HIE services. CMS will consult with the Office of the National Coordinator (ONC) for Health Information Technology, which has awarded HIE grants in all States and Territories to determine, on a case-by-case basis, the soundness of the Medicaid agency's HIE funding proposal. States should focus on obtaining proportional investments based upon market share and expected volume of transactions, as described in the Cost Allocation section of this letter. Medicaid funding must leverage and support the ONC grant funding; therefore CMS expects proposals to reflect aligned benchmarks, approaches and performance goals. CMS will examine HIT Implementation Advanced Planning Documents (HIT IAPDs) to ensure that States adopt HIE approaches that maximize return on investment and minimize project risk, including review of State's benchmarks, approaches, and performance measures related to State IT systems and meaningful use progress. This approach is consistent with the process by which CMS will work with States to ensure they meet the seven standards and conditions for receiving enhanced FFP for Medicaid technology investments.

CMS reminds States that the Medical Loss Ratio interim final rule published on December 1, 2010, makes references, at 45 CFR 158.151, to health information technology expenses that a private health insurance issuer may include in the share of the premium that must be devoted to health care services and quality improvement, such as those that provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible, "…and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with the Medicare and/or Medicaid meaningful use requirements…." States may find it helpful when meeting with health plan stakeholders to emphasize that if they provide funding for health information exchange activities, such expense may be considered an allowable quality improving activity that may be reported as part of the 80-85% of premium revenue that must be devoted to clinical services and quality improvement if such expenses satisfy the criteria set forth in the Medical Loss Ratio interim final rule.

In order to confirm that other payers and providers will contribute an appropriate share of costs, States will be required to seek legal agreements (i.e., Memoranda of Understanding) with their HIE partners. These agreements should clearly outline the terms (scope, budget and timing) of each party's contributions in the near- and long-term functioning of the HIE. States should anticipate scenarios where additional payers and providers invest as the HIE(s) mature. Therefore, States should describe to CMS how early investor benefits will be handled, e.g., offering lower costs once others join and costs are allocated among a greater number of participants. The agreements between State Medicaid Agencies and other payers and providers must be submitted to CMS for review along with the State's HIT IAPD. While this degree of planning and business modeling may require intensive public/private negotiations within each State, CMS believes it is necessary and will not approve 90/10 funding for HIE infrastructure costs (such as those cited in the August 2010 SMD letter) without assurances that other payers and providers will bear an appropriate share of the costs, risks and governance. These agreements are just one indicator of other payers' commitment to HIE and as such, changes to these agreements will be reviewed by CMS along with the other performance metrics referenced above on an annual basis.

States may fund the non-federal share consistent with federal rules and regulations at section 1903(w)(6)(A) and 42 CFR 433.51. CMS will review the non-federal share funding sources on an individual basis using information provided by the State and gathered by CMS staff. Please be mindful that all sources of the non-Federal share and any fees, taxes, or donations must meet the requirements of section 1903(w) of the Social Security Act, implementing regulations, CMS guidance, and other applicable laws, rules, and regulations.

Cost Allocation

Cost allocation principles, as defined by OMB Circular A-87, should be utilized where entities other than the Medicaid agency stand to benefit in the results of the activity. In determining Medicaid's share of the costs towards building HIE, CMS will consider different allocation approaches depending upon whether the State is requesting Medicaid Management Information System (MMIS) or HITECH administrative funding, as follows:

- When the HIE functions directly relate to MITA business services and are necessary to enable them, and/or there are interfaces to the MMIS from external HIE entities, States may seek MMIS matching funds for the interfaces or connections between the MMIS and the HIE. These States should calculate the Medicaid-eligible percentage of their total covered population; or the percentage of total healthcare expenditures within the State that are Medicaid expenditures. That percentage will be Medicaid's allocated share.
- If the State Medicaid agency is seeking HITECH funds directly tied to the Medicaid EHR Incentive Program, States may calculate the percentage of all providers the State projects will receive Medicaid EHR incentives over the next five years from the onset of proposed HIE activities to the State's total number of providers. For example, if there are 10,000 providers in the State, and the State projects that 500 of them will receive Medicaid EHR incentives within five years, then Medicaid's allocated share would be five percent. States' environmental scans ("As-Is" HIT assessments) should support these projections.
- If the activity to be funded does not meet the criteria of this letter, or the August 2010 letter, then States wishing to request the 50 percent match for general program administration must provide justification as to how the HIE activity supports the Medicaid enterprise, and if approved, should calculate the Medicaid allocation using one of the MMIS cost allocation formulas described above.

Statewide Efficiencies

CMS recognizes that there are several types of HIE models emerging in the U.S. and that not all involve statewide services or governance, and will review each proposal individually. However, CMS encourages a State's HIE model to include the following characteristics:

- Deploys a statewide layer of HIE services or orchestrate existing sub-state nodes;
- Plays a significant role in the collection of Medicaid providers' meaningful use attestations and clinical quality measure data;
- Is directly focused on enabling providers to meet meaningful use requirements, such as lab results and clinical summary exchange;
- Provides immediate value to providers through affordable services that help them meet meaningful use requirements and coordinate and improve patient care;

- Is governed by state-level policies, accreditation processes and exchange standards that are aligned with Federal policy; and
- Is actively engaged with State government.

State Medicaid HIT Plans (SMHPs) and IAPDs should clearly describe the rationale for the HIE model selected from the perspective of benefits and risks to the Medicaid agency. If a proposed model does not include the characteristics above, the State should provide justification of why an alternate model is more appropriate given unique circumstances in that State. ONC will be a full partner with CMS in the evaluation of State Medicaid agencies' HIE funding proposals for consistency and alignment with the ONC funded cooperative agreements, and Nationwide Health Information Network (NwHIN) initiatives including Direct and Exchange. The funding proposal should also detail how the costs will transition from infrastructure build to operations and maintenance.

Sustaining Operational HIE

One of the Guiding Principles in the August 2010 letter was that HITECH funds are meant to support time-limited activities. In the context of HIE, examples include the development or expansion of provider directories, master patient indexes and laboratory interfaces. Once established and functional- and based upon the degree of provider enrollment and transaction volume, the funding perspective should shift from design and development to supporting ongoing operations and maintenance costs. There are some States where operational HIEs already exists; these States may seek Federal matching funds to sustain ongoing operational costs. Per our August 2010 SMD letter, under that scenario, CMS believes that the most appropriate means to support HIE is through adjustments to provider reimbursement methodologies, which are matched at a State's Federal medical assistance percentage (FMAP), and/or through the 50 percent match rate for general program administration if the HIE is related to administering Medicaid. States wishing to pursue HIE maintenance through provider reimbursement are encouraged to submit a State Plan amendment to their CMS regional office.

States are encouraged to consult with CMS in advance of formal SMHP and IAPD updated submissions to obtain technical assistance regarding the funding options and boundaries outlined in this SMD letter. States should reach out to their CMS regional office's Medicaid HIT staff lead as the initial point of contact. We believe that by taking a collaborative and informed approach, Federal and State investments can be carefully and measurably directed to develop and support HIE. Whether HIE is employed as part of meaningful use of EHRs, for enhancing care coordination and medical home strategies, or as enablers of new provider payment models, HIE is an essential tool in improving individual and population health and reducing unnecessary costs.

This letter provides three additional parameters to an existing collection of information that had been approved by OMB under control number 0938-1088 (CMS-10292). CMS is seeking OMB approval of those parameters which include the voluntary submission of information concerning the HIE business and sustainability model, HIE-specific performance metrics, and other payer contributions to HIE infrastructure build. To initiate the approval process, the 60-day notice

seeking public comment will be placed on public display on May 17, 2011 and will publish in the Federal Register on May 18, 2011.

For further information or clarification on this State Medicaid Director letter, please contact Mr. Rick Friedman at 410-786-4451, or Richard.Friedman@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

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