Health Information Exchange Providers Incentive Program **FY2017 Request: $4,080,000**
Reference No: AMD 61563

AP/AL: Appropriation
Project Type: Life / Health / Safety
Category: Health/Human Services
Location: Statewide
House District: Statewide (HD 1-40)
Impact House District: Statewide (HD 1-40)
Contact: Michael Frawley
Estimated Project Dates: 07/01/2016 - 06/30/2021
Contact Phone: (907)465-1870

Brief Summary and Statement of Need:
New Centers for Medicare and Medicaid Services (CMS) Tribal claiming policy requires Tribal and non-tribal providers to ensure that services provided by non-tribal providers are tracked and managed by the Tribal provider. The most effective method of tracking services is through a Health Information Exchange (HIE), however not all providers are currently capable of HIE reporting. This project allows the State to enable providers to link to the HIE, removing a key barrier to utilization of the new CMS Tribal claiming policy.

Funding:	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	Total
1002 Fed Rcpts	$3,600,000						$3,600,000
1003 G/F Match	$480,000						$480,000
Total:	$4,080,000	$0	$0	$0	$0	$0	$4,080,000

☐ State Match Required ☑ One-Time Project ☐ Phased - new ☐ Phased - underway ☐ On-Going
0% = Minimum State Match % Required ☑ Amendment ☐ Mental Health Bill

Operating & Maintenance Costs:

	Amount	Staff
Project Development:	0	0
Ongoing Operating:	0	0
One-Time Startup:	0	
Totals:	0	0

Prior Funding History / Additional Information:

No prior funding history.

Project Description/Justification:
This project assists the Department of Health and Social Services in receiving a 100 percent Federal Medical Assistance Percentage (FMAP) rate for state expenditures incurred within the Medicaid program when an Alaska Native receives services from a non-Indian Health Services (IHS)/Tribal provider through a care coordination agreement with an IHS/Tribal provider. The Centers for Medicare and Medicaid Services' (CMS) policy provides that in order to receive the 100 percent FMAP rate, the IHS/Tribal provider remains responsible for overseeing the patient's care and the IHS/Tribal provider retains control of the patient's medical records. The maintenance of medical records will be made possible through the use of a Health Information Exchange (HIE).

The Department of Health and Social Services will provide incentive or grant payments to Medicaid providers to support their ability to connect or onboard to the HIE. The Centers for Medicare and Medicaid Services' Health Information Technology for Economical and Clinical Health (HITECH)

administrative matching funds are available to fund 90 percent of the incentive payments. State general funds are used to provide the 10 percent match requirement.

CMS published a State Medicaid Director's letter on February 29, 2016, which allows federal financial support of onboarding Medicaid providers to HIEs that support the professionals and hospitals that are eligible for the Medicaid Electronic Health Record (EHR) Incentive Payment Program and their ability to achieve meaningful use.

This project supports:

- Activities in the Medicaid Reform bill, SB74, section 38, Tribal Medicaid Reimbursement
- Activities associated with the CMS State Medicaid Director's letter #16-002: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives
- Activities associated with the CMS State Medicaid Director's letter #16-003: Availability of HITECH Administrative Matching Funds to help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers

Based on projections provided by the Alaska eHealth Network, the cost obligation for this type of incentive would be:

- Total number of projected provider organizations: 100 (includes primary care, specialty, behavioral health, others such as case managers or similar)
- Average cost per EHR per site (meaning that if a provider organization has 10 practitioners, and all are using a single EHR solution, these costs would be applied just once for the EHR not 10 times for each practitioner): $40,000/per EHR

Costs would include project management, administrative costs, interface development, and training. Providers will use incentive dollars to pay for the connection and/or interface of their Electronic Health Record solutions (which is an IT solution the provider already owns) to the HIE, or for fee-for-service, web-based query access of the HIE because they do not have/own an Electronic Health Record solution.

Cost Breakdown

Project Management & Administrative Cost	$9,000
System Interface Cost	$30,000
Training Cost	$1,000

Project Management and Administrative Costs include: data coordination, standardization, marketing, contracting, participant liaison/coordination, account management, coordination of statewide planning for all HIE participants and other general administrative costs.

Funding Breakdown

Federal	$3,600,000
State General Funds (GF/Match)	$400,000
Capital Fund Administration (GF/Match)	$80,000
Total cost for incentives to 100 provider organizations	$4,080,000

Capital Fund Administration Costs include: general administrative costs for Capital project management.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

SHO #16-002

Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

February 26, 2016

Dear State Health Official:

The purpose of this letter is to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. As described in this letter, IHS/Tribal facilities[1] may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below. This update in payment policy is intended to help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

Background

The IHS, a federal agency within the Department of Health and Human Services, is responsible for furnishing comprehensive, culturally-appropriate health services to almost 2.2 million AI/ANs who are eligible for services from the IHS, per regulations at 42 CFR Part 136. To achieve this goal, IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHPs) under title V of the Indian Health Care Improvement Act, P.L. 94-437, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states.[2]

[1] For purposes of this document, Tribal facilities are facilities that are operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

[2] As of the date of this SHO, the states are: AL, AK, AZ, CA, CO, CT, FL, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MS, MT, NE, NV, NM, NY, NC, ND, OK, OR, RI, SC, SD, TX, UT, WA, WI, and WY. This list is subject to change.

AI/ANs who meet the eligibility requirements for the Medicaid program in the state in which they reside are entitled to Medicaid coverage, whether or not they are eligible for services from IHS. IHS-eligible AI/ANs who are also Medicaid beneficiaries may choose to receive covered services from an IHS facility, a Tribal facility, a UIHP, or from any other provider participating in a state's Medicaid program.

Under section 1905(b) of the Social Security Act, the federal government is required to match state expenditures at the Federal Medical Assistance Percentage (FMAP) rate, which is 100 percent for state expenditures on behalf of AI/AN Medicaid beneficiaries for covered services "received through" an Indian Health Service facility whether operated by the Indian Health Service or by a Tribe or Tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)." If services are not "received through" an IHS/Tribal facility, the federal government will match the state's payment for the services at the state's regular FMAP rate, which in FY 2016 ranges from 50.00 percent to 74.17 percent.

Our long-standing interpretation of this statutory provision as reflected in sub-regulatory guidance,[3] Departmental Appeals Board decisions,[4] and federal court decisions,[5] has been that 100 percent FMAP is available for amounts expended for services under the following circumstances:

(1) The service must be furnished to a Medicaid-eligible AI/AN;
(2) The service must be a "facility service" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
(3) The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility's services; and
(4) The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

Last year, the Centers for Medicare & Medicaid Services (CMS) announced it was strongly considering re-interpreting the statutory language to expand the services it considers "received through" an IHS/Tribal facility and eligible for the 100 percent FMAP. Specifically, in October 2015, we posted on the CMS Medicaid.gov website a Request for Comment, in which we sought comments on a proposal to re-interpret the statutory language providing 100 percent FMAP for "services received through an IHS facility" by: (1) Modifying the scope of services eligible for enhanced FMAP; (2) Expanding the meaning of contractual agent to be an enrolled Medicaid provider that provides services that are identified in the state's approved Medicaid plan and are arranged for and overseen by the IHS/Tribal facility; and (3) Increasing the flexibility for billing arrangements so that IHS/Tribal facilities or their contractual agents could bill Medicaid directly for services. CMS received 182 comments from 91 commenters including Tribes, Tribal

[3] Memorandum of Agreement (MOA) between IHS and HCFA (July 11, 1996); HCFA Memorandum to Associate Regional Administrators (May, 1997).

[4] *North Dakota Dept. of Human Services*, DAB No. 1854 (2002); *South Dakota Dept. of Social Services*, DAB No. 1847 (2002); *Arizona Health Care Cost Containment System*, DAB No. 1779 (2001); *Alaska Department of Health and Social Services*, DAB No. 1919 (2004).

[5] *North Dakota ex. Rel. Olson v. Centers for Medicare & Medicaid Services*, 403 F.3d 537 (8th Cir. 2005); *Alaska Department of Health & Social Services v. Centers for Medicare & Medicaid Services*, 424 F. 3rd 931 (9th Cir. 2005); *Arizona Health Care Cost Containment System v. McClellan*, 508 F.3rd 1243 (9th Cir. 2007).

organizations, Urban Indian Health Organizations, states, and other stakeholders. We have reviewed and considered those comments in establishing this new policy interpretation.

Permitting a Wider Scope of Services

In this letter, we are re-interpreting the scope of services considered to be "received through" an IHS/Tribal facility. Under our previous interpretation, in order to be "received through" an IHS/Tribal facility, and therefore, qualify for 100 percent FMAP, the service had to be a "facility service." By that, we meant that it had to be within the scope of services that a Medicaid facility of the same type (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can provide under Medicaid law and regulation. Under our new interpretation, as described more fully below, the scope of services that can be considered to be "received through" an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS). Medicaid coverable benefit categories include all 1905(a), 1915(i), 1915(j), 1915(k), 1945, and 1915(c) services set forth in the state plan, as well as any other authority established in the future as a state plan benefit.

This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan. Under regulations at 42 CFR 440.170(a), a state can elect to cover transportation and other related travel expenses determined necessary to secure medical examinations and treatment for a beneficiary. Related travel expenses include the cost of meals and lodging en route to and from medical care, and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary. Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

This new interpretation does not provide authority for states to require any AI/AN Medicaid beneficiary to receive services through an IHS/Tribal facility. Nothing in this letter affects the entitlement of AI/AN Medicaid beneficiaries to freedom of choice of provider under section 1902(a)(23) of the Social Security Act. State Medicaid agencies may not, directly or indirectly, require AI/ANs who are eligible for Medicaid to receive covered services from IHS/Tribal facilities for the purpose of qualifying the cost of their services for 100 percent FMAP. Similarly, neither state Medicaid agencies nor IHS/Tribal facilities may require an AI/AN Medicaid beneficiary to receive services from a non-IHS/Tribal provider to whom the facility has referred the beneficiary for care. Nor can a state delay the provision of medical assistance by requiring that beneficiaries initiate or continue a patient relationship with the IHS/Tribal facility. Finally, federal Medicaid law does not require either IHS/Tribal facilities or non-IHS/Tribal providers to enter into the written care coordination agreements described in this SHO.

Request for Services In Accordance With a Written Care Coordination Agreement

In this letter, CMS also revises its interpretation to provide that a service may be considered "received through" an IHS/Tribal facility when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement meeting the criteria described below. The purpose of this revised policy interpretation is to enable

IHS/Tribal facilities to expand the scope of services they are able to offer to their AI/AN patients while ensuring coordination of care in accordance with best medical practice standards.
A covered service will be considered to be "received through" an IHS/Tribal facility not only when the service is furnished directly by the facility to a Medicaid-eligible AI/AN patient, but also when the service is furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner's care in accordance with a written care coordination agreement meeting the requirements described below. Under this policy, both the IHS/Tribal facility and the non-IHS/Tribal provider must be enrolled in the state's Medicaid program as rendering providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. Third, care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility practitioner remains responsible for overseeing his or her patient's care and the IHS/Tribal facility retains control of the patient's medical record.

A non-IHS/Tribal provider from which an IHS/Tribal facility practitioner could request services could include an Urban Indian Health Organization that participates in Medicaid, or any other Medicaid-participating provider. Furthermore, the relationship between the IHS/Tribal facility practitioner and the patient could be based on visits, including the initial visit, through telehealth procedures that meet state and/or IHS standards for such procedures, if the IHS/Tribal facility has that capacity[6].

A self-request by the beneficiary, or a request from a non-IHS/Tribal provider, does not suffice for purposes of 100 percent FMAP; in such circumstances, the non-IHS/Tribal provider could furnish the service and bill the state Medicaid program, but the state expenditure for the service would not qualify for 100 percent FMAP. Similarly, the non-IHS/Tribal provider may refer the facility patient to another non-IHS/Tribal provider; however, if the patient receives a covered service from that other provider without a request from the IHS/Tribal facility practitioner, or the IHS/Tribal facility practitioner does not remain responsible for the patient's care, the state expenditure for the service would not qualify for 100 percent FMAP.
At a minimum, care coordination will involve:

(1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;
(2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
(3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
(4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

Written care coordination agreements under this policy could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and,

[6] Or as specified in a demonstration project authorized under section 1637 of the Indian Health Care Improvement Act.

to the extent it is consistent with IHS authority, would not be governed by federal procurement rules. The IHS/Tribal facility may decide the form of the written agreement that is executed with the non-IHS/Tribal provider.

Medicaid Billing and Payments to Non-IHS/Tribal Providers

For services provided to Medicaid-eligible AI/AN beneficiaries that are rendered by a non-IHS/Tribal provider in accordance with a written care coordination arrangement, there are several options regarding how those services may be billed to Medicaid.

The first option is for the non-IHS/Tribal provider to bill the Medicaid agency directly. If the non-IHS/Tribal provider bills the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and service rendered. To support the application of the 100 percent FMAP, the state should ensure that claims include fields that document that the item or service was "received through" an IHS/Tribal facility. When a non-IHS provider bills a state directly, the state's payment rate for a covered service furnished by a non-IHS/Tribal provider to an AI/AN Medicaid beneficiary under a written care coordination agreement must be the same as the rate for that service furnished by that provider to a non-AI/AN beneficiary or to an AI/AN beneficiary who self-refers to the provider. Similarly, a state agency cannot establish one rate for services furnished by the facility to AI/AN beneficiaries and another for the same services provided by that facility to non-AI/AN Medicaid beneficiaries.

A second option is for the IHS or Tribal facility to handle all billing. In that case, the IHS/Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under agreement that can be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") from those that cannot. Inpatient services that are furnished by non-IHS providers outside of IHS/Tribal facilities could never be claimed as IHS/Tribal facility services. For IHS, other services provided by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. Tribal facilities generally may have more flexibility than IHS and should consult with their state to determine the circumstances in which other services provided by non-Tribal providers can be claimed as Tribal facility services. The circumstances under which Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, Federally Qualified Health Centers, etc.). Services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and are paid at the applicable Medicaid state plan IHS/Tribal facility rate. For all other services provided by non-IHS/Tribal providers, IHS or the Tribe could bill for these services as an assigned claim by that provider and the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate. These services are still eligible for the 100 percent FMAP, provided other requirements have been met.

The billing arrangement should be reflected in the written agreement between the IHS/Tribal facility and the non-IHS/Tribal provider. Payment methodologies for facility services furnished by both the IHS/Tribal facility and rate methodologies paid to non-IHS/Tribal providers must be set forth in an approved state Medicaid plan. Payment rates can reflect the unique access concerns in particular geographic areas, or with respect to certain types of providers. However, rates may not vary based on the applicable FMAP. States should review existing state plans to ensure compliance with the policy articulated in this letter.

Managed Care

The discussion above assumes that the Medicaid-eligible AI/AN has "received [services] through" the IHS/Tribal facility on a fee-for-service basis. In some cases, however, Medicaid-eligible AI/ANs may be enrolled in a risk-based Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), in which case the state Medicaid agency is making monthly capitation payments on behalf of the AI/AN enrollee to the MCO, PIHP, or PAHP. The state may claim 100 percent FMAP for the portion of the capitation payment attributable to the cost of services "received through" an IHS/Tribal facility if the following conditions are met:

(1) The service is furnished to an AI/AN Medicaid beneficiary who is enrolled in the managed care plan;

(2) The service meets the same requirements to be considered "received through" an IHS/Tribal facility as would apply in a fee-for-service delivery system and the managed care plan maintains auditable documentation to demonstrate that those requirements are met;

(3) The non-IHS/Tribal provider is a network provider of the enrollee's managed care plan;

(4) The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider's contractual agreement with the managed care plan; and

(5) The state has complied with section 1932(h)(2)(C)(ii) of the Act consistent with CMS guidance.

States would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/ANs who are enrolled in managed care, even though the state itself has made no direct payment for services "received through" an IHS/Tribal facility. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on the cost of services attributable to IHS/Tribal services or encounters received through an IHS/Tribal provider meeting the requirements outlined in this section.

Compliance and Documentation

To ensure accountability for program expenditures, in states where IHS/Tribal facilities elect to implement the policy described in this letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services "received through" an IHS/Tribal facility. The documentation must be sufficient to establish that (1) the item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner; (2) the requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care; (3) the rate of payment is authorized under the state plan and is consistent with the requirements set forth in this letter; and (4) there is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

Applicability to Section 1115 Demonstrations

State expenditures for services covered under section 1115 demonstration authority are eligible for 100 percent FMAP as long as all of the elements of being "received through" an IHS or Tribal facility that are described in this SHO are present.

Relationship Between 100 Percent FMAP for Tribal Services and Other Federal Matching Rates
The 100 percent FMAP for services "received through" an IHS/Tribal facility is available for services provided to AI/ANs as described in this SHO instead of the regular FMAP rate described in section 1905(b) of the Act, the newly eligible FMAP rate described in section 1905(y) of the Act, the enhanced FMAP rate for breast and cervical cancer, or the enhanced rate for Community First Choice services.

We intend to issue additional guidance materials after the release of this SHO. CMS is available to work closely with each state to implement the policy established in this state health official letter regarding receiving 100 percent FMAP for services "received through" an IHS/Tribal facility. If you have any questions regarding this information, please contact TribalAffairs@cms.hhs.gov or Kirsten Jensen, Director, Division of Benefits and Coverage, 410-786-8146.

Sincerely,
/s/
Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

American Public Human Services Association

National Governors Association

Council of State Governments

Association of State and Territorial Health Officials

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
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SMD# 16-003

RE: Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers

February 29, 2016

Dear State Medicaid Director:

This letter updates guidance issued by the Centers for Medicare & Medicaid Services (CMS) about the availability of federal funding at the 90 percent matching rate for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers. CMS previously issued guidance on this topic in State Medicaid Director (SMD) Letter #10-016 (August 17, 2010)[1], SMD Letter #11-004 (May 18, 2011)[2], and a 2013 guidance document, "CMS Answers to Frequently Asked Questions (9/10/2013)" (2013 guidance).

This updated guidance expands the scope of State expenditures eligible for the 90 percent matching rate, and supports the goals of, "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0,"[3] published by the Department of Health and Human Services, Office of the National Coordinator (ONC) for Health Information Technology, on October 6, 2015. In this letter, we are expanding our interpretation of the scope of State expenditures eligible for the 90 percent HITECH match, given the greater importance of coordination of care across providers and transitions of care in Meaningful Use modified Stage 2 and Stage 3. This letter supersedes the 2013 guidance but many of the principles of that guidance, as indicated in this letter, remain valid. We intend to issue updated, detailed guidance that integrates those principles with the interpretive changes set forth in this letter.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, added sections 1903(a)(3)(F) and 1903(t) to the Social Security Act. These provisions make available to States 100 percent Federal matching funding for incentive payments to eligible Medicaid providers to encourage the adoption and use of certified EHR technology through 2021, and 90 percent Federal matching funding (the 90 percent HITECH match) for State administrative expenses related to the program, including State administrative expenses related to pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information, subject to CMS approval. CMS has implemented these

[1] Available at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10016.pdf
[2] Available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD11004.pdf
[3] Available at https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf

provisions in regulations at 42 CFR Part 495. When attesting to Meaningful Use modified Stage 2 or Stage 3, professionals and hospitals that are eligible for Medicaid EHR Incentive Payments (collectively referred to in this document as Eligible Providers) must demonstrate the ability to electronically coordinate with other providers across care settings under the CMS regulations at 42 CFR Part 495. In order to meet these Meaningful Use objectives, Eligible Providers will often need to electronically coordinate care with other Medicaid providers that are not eligible for Medicaid EHR incentive payments.

SMD Letters #10-016 and #11-004 explained that state costs related to HIE promotion may be matched at the 90 percent HITECH matching rate only if they can be directly correlated to the Medicaid EHR Incentive Program. In the 2013 guidance, we therefore explained that States' costs of facilitating connections for providers to an HIE may be matched at the 90 percent HITECH matching rate only if the providers are Eligible Providers. We now explain that State costs of facilitating connections between Eligible Providers and other Medicaid providers (for example, through an HIE or other interoperable systems), or costs of other activities that promote other Medicaid providers' use of EHR and HIE, can also be matched at the 90 percent HITECH matching rate, but only if State expenditures on these activities help Eligible Providers meet the Meaningful Use objectives. Subject to CMS prior approval, States may thus be able to claim 90 percent HITECH match for expenditures related to connecting Eligible Providers to other Medicaid providers, including behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers.

For example, an Eligible Provider might be a physician needing to meet the modified Stage 2 or Stage 3 Meaningful Use objective for health information exchange (*see* 42 CFR 495.22(e)(5)(i) or 495.24(d)(7)(i)(A)) when transitioning patients to another Medicaid provider such as a nursing facility, or a home health care provider. Or an eligible hospital might need to meet the objective for Medication Reconciliation and compare records with other providers to confirm that the information it has on patients' medication is accurate when it admits patients into its care (*see* 42 CFR 495.22(e)(7)(i) or 495.24(d)(7)(ii)(B)(3)(i)). Subject to CMS approval, States can claim 90 percent HITECH match in the costs of developing connectivity between Eligible Providers (whether eligible professionals or eligible hospitals) and other Medicaid providers if this will help the Eligible Providers demonstrate Meaningful Use.

CMS explicitly encourages and welcomes multistate collaboratives partnering on shared solutions for HIE and interoperability, including for the activities discussed in this letter (facilitation of EHR Meaningful Use and related communications through the HIE system). CMS will aggressively support such collaboratives as potentially cost-saving opportunities to increase adoption of interoperability standards and help Eligible Providers demonstrate Meaningful Use. Such collaboratives should promote Medicaid Information Technology Architecture (MITA) principles on scalability, reusability, modularity, and interoperability. We note that ONC is a willing partner in helping States develop open source and open architecture tools for HIE that are consistent with MITA principles.

Cost controls, cost allocations, and other payers

States must ensure that any 90 percent HITECH match claimed under the guidance in this letter supports Eligible Providers' demonstration of Meaningful Use modified Stage 2 and Stage 3, and must therefore report on the extent to which the activities they are funding help Eligible Providers demonstrate Meaningful Use. CMS will require States to describe in advance which specific Meaningful Use measures they intend to support in the Implementation Advance Planning Document (IAPD) as well as to confirm such measures are indeed supported post-implementation. Under no circumstances may States claim 90 percent HITECH match in the costs of actually providing EHR technology to providers or supplementing the functionality of provider EHR systems. This funding is available, subject to CMS approval, as of the date of this letter, and will not be available retroactively.

Additionally, States should claim the 90 percent HITECH match for HIE-related costs relating to Medicaid providers that are not eligible for Medicaid EHR incentive payments only if those HIE-related costs help Eligible Providers demonstrate Meaningful Use. For example, it would not be appropriate for States to claim the 90 percent HITECH match for costs related to an HIE system that did not connect to or include Eligible Providers and therefore would not help Eligible Providers demonstrate Meaningful Use.

States should continue to adhere to the guidance in SMD Letter #11-004 detailing how Medicaid funding should be part of an overall financial plan that leverages multiple public and private funding sources to develop HIEs. Similarly, States are reminded that per SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs. This updated guidance makes no changes to the general cost allocation principles and fair share principles States should follow in proposing funding models to CMS for HIEs or interoperable systems, although under this updated guidance, the Medicaid portion of such cost allocations may increase to include costs associated with connecting Eligible Providers to other Medicaid providers. CMS has approved several different cost allocation methodologies for States and those various methodologies will be affected differently by this guidance. CMS will provide technical assistance on the impact of this guidance on specific States. Similarly, States should continue to complete and update the "Health Information Technology Implementation Advance Planning Document (HIT IAPD) Template[4]," developed by CMS and the Office of Management and Budget, in which States detail cost allocation models and other financial considerations. States should meet with CMS to review cost allocation models that carefully consider the extent to which the HIE or other interoperable system benefits Eligible Providers, other Medicaid providers, non-Medicaid providers, and other payers.

Medicaid Information Technology Architecture (MITA) emphasizes the importance of interoperability and industry standards. States should take an aggressive approach to HIE and interoperability governance for purposes of supporting interoperability while focusing on security and standards to keep interface costs to a minimum. The CMS final rule published on December 4, 2015, "Mechanized Claims Processing & Information Retrieval Systems (90/10)"

[4] https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/medicaid_hit_iapd_template.pdf

requires in 42 CFR 433.112 a new focus on industry standards in MITA that support more efficient, standards-based information exchange as described in 45 CFR Part 170. Specifically, 45 CFR Part 170 defines the Common Clinical Data Set, transport standards, functional standards, content exchange standards and implementation specifications for exchanging electronic health information, and vocabulary standards for representing electronic health information. In implementing these standards, we encourage States to develop partnerships with non-profit collaboratives and other industry participants such as DirectTrust that further support Direct Secure Messaging through trust frameworks that reduce the costs and technical complexities of electronic health information exchange for providers.

The interoperable systems described in this letter are part of the MITA and interfaces to these systems should appropriately follow a Service-Oriented Architecture (SOA) as well as adhere to industry standards. States should aggressively pursue HIE and interoperability solutions for Medicaid providers that either obviate the need for costly interfaces, or utilize open architecture solutions that make such interfaces easily acquired. For example, consistent with the software ownership rights held by the state under 45 CFR § 95.617, States might require that HIE interfaces designed, developed, or installed with Federal financial participation be made available at reduced or no cost to other Medicaid providers connecting to the same HIE. Furthermore, States could require that such interfaces (or the code for such interfaces) be made publicly available. Additionally, CMS and ONC support States in sharing open source tools and interfaces with other States to further drive down the costs of HIEs, interfaces, and other interoperable systems.

States are also reminded that careful alignment and coordination with other funding sources should be thoroughly discussed with CMS and addressed in an Implementation Advance Planning Document Update (IAPD-U), specifically Appendix D. States continue to be encouraged to consult with CMS in advance of formal State Medicaid HIT Plan (SMHP) and IAPD submissions to obtain technical assistance regarding the funding options and boundaries outlined in this and the previous SMD Letters, and additional technical assistance will be provided when we release an update to the 2013 guidance that reflects the new criteria for the 90 percent HITECH match described here. States should reach out to their CMS regional office's Medicaid HIT staff lead as the initial point of contact.

Below are some examples of the types of state costs for which 90 percent HITECH match might be available, subject to CMS approval.

Federal Financial Participation (FFP) for On-boarding Medicaid providers to HIEs or interoperable systems

On-boarding is the technical and administrative process by which a provider joins an HIE or interoperable system and secure communications are established and all appropriate Business Associate Agreements, contracts and consents are put in place. State activities related to on-boarding might include the HIE's activities involved in connecting a provider to the HIE so that the provider is able to successfully exchange data and use the HIE's services. The 90 percent HITECH match is available to cover a state's reasonable costs (e.g., interfaces and testing) to on-board providers to an HIE. Subject to the parameters and cost controls described above, States

may claim 90 percent HITECH match for state costs of supporting the initial on-boarding of Medicaid providers onto an HIE, or onto any interoperable system that connects Eligible Providers to other Medicaid providers. Costs can be claimed both if they are incurred by the state to support the initial on-boarding of Eligible Providers and if they are incurred by the state to support the on-boarding of other Medicaid providers, provided that connecting the other Medicaid providers helps Eligible Providers demonstrate, and meet requirements for, Meaningful Use. States should coordinate with CMS on defining benchmarks and targets for on-boarding providers. States are reminded that, consistent with the principles described in both SMD Letter #10-016 and SMD Letter #11-004, the 90 percent HITECH match is for implementation only, and States should work with CMS on establishing an endpoint to onboarding and always ensure costs are allocated as appropriate across other payers. Also, the scope of the onboarding should be clearly defined and reviewed with CMS prior to IAPD submission to ensure that any costs claimed help Eligible Providers meet Meaningful Use and to ensure that HIE-related costs benefiting providers that are not eligible for Medicaid EHR incentive payments are claimed only if these costs help Eligible Providers demonstrate Meaningful Use. States should generally refer to SMD Letters #10-016 and #11-004 for other information about allowable onboarding costs.

Pharmacies: Similarly, subject to the parameters and cost controls described above, States may claim the 90 percent HITECH match for the costs of supporting the initial on-boarding of pharmacies to HIEs or other interoperable systems, if on-boarding the pharmacies helps Eligible Providers meet Meaningful Use objectives, such as the objectives around sending electronic prescriptions or the objectives around conducting medication reconciliations, both described in 42 CFR 495.22 and 495.24.

Clinical Laboratories: Subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of supporting the initial on-boarding of clinical laboratories to HIEs or interoperable systems, if on-boarding these laboratories helps Eligible Providers meet Meaningful Use objectives, such as the objectives for Electronic Reportable Lab Results or laboratory orders in Computerized Provider Order Entry (CPOE) described in 42 CFR 495.22 and 495.24.

Public Health Providers: Similarly, subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of on-boarding Medicaid public health providers to interoperable systems and HIEs connected to Eligible Providers so that Eligible Providers are able to meet Meaningful Use measures focused on public health reporting and the exchange of public health data, including activities such as validation and testing for reporting of public health measures described in 42 CFR 495.22 and 495.24.

FFP for interoperability and HIE architecture

As with expenses for on-boarding, States may claim 90 percent HITECH match for their costs of connecting Eligible Providers to other Medicaid providers via HIEs or other interoperable systems, if doing so helps Eligible Providers demonstrate Meaningful Use and the cost controls described above are met.

Specifically, 90 percent HITECH match would be available for States' costs related to the design, development, and implementation of infrastructure for several HIE components and interoperable systems that most directly support Eligible Providers in coordinating care with other Medicaid providers in order to demonstrate Meaningful Use. As described in SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs after this technology is established and functional. These components and systems include:

Provider Directories: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of provider directories that allow for the exchange of secure messages and structured data to coordinate care or calculate clinical quality measures between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. The 90 percent HITECH match would not be appropriate for costs of developing a separate subdirectory for a class of providers that are not eligible for Medicaid EHR incentive payments and that are unlikely ever to exchange records with an Eligible Provider. CMS emphasizes the importance of dynamic provider directories with, as appropriate, bidirectional communications to public health agencies and public health registries. CMS particularly supports approaches to provider directories that provide solutions for Eligible Providers to connect to other Medicaid providers with lower EHR adoption rates, if doing so helps the Eligible Providers demonstrate Meaningful Use. Secure, web-based provider directories, for example, might help Eligible Providers coordinate care more effectively with long term care providers, behavioral health providers, substance abuse providers, etc. CMS expects that States will consider provider directories as a Medicaid enterprise asset that can also support Medicaid Management Information System (MMIS) functionality, with the reminder that, per SMD Letter #10-016, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Secure Electronic Messaging: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of secure messaging solutions that connect Eligible Providers to other Medicaid providers and allow for the exchange of secure messages and structured data, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. States are encouraged to utilize Direct Secure Messaging as a transport standard that is secure and scalable. States should refer to the "Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 Through 2017" rule for guidance on meeting the Certified Electronic Health Record Technology (CEHRT) requirements for purposes of Meaningful Use[5]. States may also refer to ONC's 2016 Interoperability Standards Advisory (ISA), a publication that provides the identification, assessment, and determination of the "best available" interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs[6]. States should also be prescriptive in governance requirements to ensure maximal interoperability in the most secure and efficient manner possible. ONC is a willing partner with CMS in helping States deploy Direct Secure Messaging systems and developing

[5] https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications
[6] https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf

related governance requirements to ensure that Eligible Providers can connect to other Medicaid providers.

Query Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of query-based health information exchange, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. States may support coordination of care between Eligible Providers and other Medicaid providers by linking them into a query-based HIE that allows for secure, standards-based information exchange with thorough identity management protocols. A Query Exchange might access a state's Clinical Data Warehouse and similarly be integrated with analytic and reporting functions. These activities may support aggregate queries from providers to support population health activities performed by public health or other entities involved in population health improvement, provided that doing so helps Eligible Providers meet Meaningful Use. Given the unique data and exchange governance challenges of Query Exchange, States are encouraged to reach out to ONC to help formulate governance guidance and best practices.

Care Plan Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of interoperable systems and HIEs that facilitate the exchange of electronic care plans between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. Medicaid providers coordinating care across multiple care settings may exchange care plans containing treatment plans and goals, as well as problem lists, medication history and other clinical and non-clinical content added and updated as appropriate by members of a patient's care team, including Medicaid social service providers. States are encouraged to consider care plan exchange for patients with multiple chronic conditions who might be coordinating care between many specialists, hospital(s), long term care facilities, rehabilitation centers, home health care providers, or other Medicaid community-based providers. Similarly, children in the foster care system might benefit from care plans shared across Medicaid providers (including Eligible Providers) to facilitate coordination of the children's care. As discussed above, costs related to exchanging care plans between Medicaid providers and other programs, such as foster care programs, may need to be allocated between benefitting programs.

Encounter Alerting: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of communications within an HIE or interoperable system connecting Eligible Providers and other Medicaid providers about the admission, discharge or transfer of Medicaid patients, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. These communications among Medicaid providers may contain structured data regarding treatment plans, medication history, drug allergies, or other secure content that aids in the coordination of patient care, including coordination of social services as appropriate.

Public Health Systems: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of public health systems and connections to public health systems, so long as the cost controls described above are met, and so long as these costs help Eligible Providers meet Meaningful Use measures focused on public health reporting and the exchange of public health data described in 42 CFR 495.22 and 495.24. It is worth

emphasizing that state costs eligible for the 90 percent HITECH match might include costs related to developing registry and system architecture for Prescription Drug Monitoring Programs (PDMPs), as per FAQ #13413[7] PDMPs can be considered a specialized registry to which Eligible Providers may submit data in order to meet Meaningful Use objectives. States should, however, keep in mind that MMIS matching funds might in some circumstances be a more appropriate source of federal funding for costs related to developing a PDMP. Again, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Health Information Services Provider (HISP) Services: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of HISP Services that coordinate the technical and administrative work of connecting Eligible Providers to other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. HISP Services may coordinate encryption standards across providers, as well as coordinate contracts, Business Associate Agreements or other consents deemed appropriate for the HIEs or interoperable systems. States should be careful to distinguish between on-boarding services and HISP Services, as the scope of HISP activities overlaps with the scope of on-boarding activities, and the state should confirm that activities are only supported with federal funding once. States should clearly define the scope of HISP activities and on-boarding activities as appropriate.

This is not an exhaustive list of the types of state costs for design, development, and implementation of HIE components and interoperable systems for which 90 percent HITECH match might be claimed. Design, development, and implementation costs associated with other HIE components and interoperable systems might be supported by the 90 percent HITECH match as long as these costs help Eligible Providers achieve Meaningful Use and meet the cost controls described above, and will be considered by CMS accordingly.

Under this updated guidance, States remain able, subject to CMS approval, to claim 90 percent HITECH match for design, development, and implementation costs related to personal health records (PHRs), as utilizing a PHR through an HIE will often be the best way for many Eligible Providers to meet the Meaningful Use modified stage 2 Patient Electronic Access objective (*see* 42 CFR 495.22(e)(8)) and/or the Meaningful Use stage 3 Coordination of Care Through Patient Engagement objective (*see* 42 CFR 495.24(d)(6)). The parameters for HITECH administrative funding discussed in SMD Letters #10-016 and #11-004 continue to be relevant to PHR funding requests from States.

Conclusion

With more States utilizing or exploring the possibilities of vehicles for delivery system reform that benefit from coordination of care, such as health homes, primary care case management, managed care, home and community-based service programs, and performance-based incentive payment structures, there is an expectation that the Medicaid Enterprise infrastructure will be designed to support these efforts. These efforts therefore support the MITA principles of

[7] https://questions.cms.gov/faq.php?faqId=13413

reusability, interoperability, and care management in providing a foundation for further delivery system reform.

As States enter the fifth year of the Medicaid EHR Incentive Program, CMS and ONC expect them to leverage available federal funding for tools and guidance to help Eligible Providers demonstrate Meaningful Use, which might include strengthening data exchange between Eligible Providers and other Medicaid providers. States may have questions about the Health Insurance Portability and Accountability Act (HIPAA) considerations applicable to creating more diverse HIEs and interoperable systems, so we have included links to guidance from the U.S. Department of Health and Human Services Office for Civil Rights and the Office of the National Coordinator for Health Information Technology describing uses and disclosures that are permitted under HIPAA[8]. Note that the discussion in the linked guidance only concerns the uses and disclosures that are permitted under HIPAA, and does not address when state costs related to the discussed activities would be eligible for the 90 percent HITECH match. This next phase of infrastructure development and connectivity will best position all Eligible Providers to successfully demonstrate Meaningful Use of Certified EHR Technology while solidifying a broader network of health information exchange among Medicaid providers, writ large.

Sincerely,

/s/

Vikki Wachino
Director

Enclosure

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures

[8] https://www.healthit.gov/sites/default/files/exchange_health_care_ops.pdf and https://www.healthit.gov/sites/default/files/exchange_treatment.pdf