
June 15, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: **CMS-2392-P**

**Re: Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)**

The American Public Human Services Association (APHSA) respectfully submits these comments on the proposed rule CMS-2392-P that would extend funding for Medicaid eligibility systems as a part of a state's mechanized claims processing and information retrieval systems, and would update conditions and standards for such systems, including updating current Medicaid Management Information Systems (MMIS) conditions and standards.

APHSA is a bipartisan, nonprofit organization representing appointed state health and human service commissioners, their top level management , including chief information officers and other IT professionals, and hundreds of county-level directors of health and human services throughout the nation. Changes to Medicaid Mechanized Claims Processing and Information Retrieval Systems and federal financial participation rates and requirements to system modernization efforts, specifically those effecting interoperable health and human service information technology systems, are of critical importance to the work of our member agencies and the people and communities they serve. As such, APHSA, with input provided through our IT Solutions Management for Human Services (ISM) affiliate, is pleased to provide you with the following comments.

## General Comments

APHSA commends the Centers for Medicare and Medicaid Services (CMS) for its inclusion of Medicaid eligibility and enrollment (E&E) systems into the definition of mechanized claims processing and information retrieval systems at 42 CFR 433.111, thereby making such systems eligible for the enhanced matching rates of 90 and 75 percent Federal Financial Participation (FFP) under section 1903(a)(3) of the Social Security Act.

In addition, we support the standards and conditions proposed in the NPRM to access enhanced funding, as well as the new definitions of "COTS", "open source", "proprietary", "shared services" and "MMIS Module" included in this Proposed Rule.

While CMS has encouraged greater interoperability between health and human service E&E systems through its leadership on the OMB Circular A-87 Exception and in its work on IT standardization, the unfortunate reality is that since the enactment of the Affordable Care Act (ACA), many states have *separated* their previously integrated E&E systems in order to meet the operational deadlines associated with the statute. On the human services side, the result has been a national step backward in terms of system modernization through the creation of two separate and unequal systems – one for Medicaid (primarily for the Medicaid MAGI population) and the other, a legacy system used for the non-MAGI Medicaid population, SNAP applications and programs administered by the Administration for Families and Children.

While understandable in the short-run, the NPRM does little to ameliorate this situation. Extending the enhanced match will provide states with the opportunity to migrate the rest of their Medicaid and CHIP programs to the new systems. There is no incentive currently in regulation to re-establish the formerly integrated health and human service systems.

The NPRM justifies the permanency of the enhanced match for Medicaid E&E on the basis that such funding "would allow the states to complete fully modernized systems and avoid the situation where its ability to serve consumers well is limited by outdated systems."

The unfortunate reality is likely to be just the opposite: two systems – one for Medicaid and one for human services – resulting in duplicative administrative costs and more than twice the burden for program participants eligible for Medicaid and any one of the many human service programs; e.g., SNAP, child welfare, LIHEAP, etc., to which they are entitled, unless steps are taken in this Final Rule to address the problem.

***To remedy this situation, APHSA recommends that:***

> ***1. Performance measures be developed by the three Federal agencies involved - CMS, ACF and USDA/FNS - to ensure states meet the Interoperability requirement of CMS' Seven Conditions & Standards. Language clearly stating what these criteria are, and that states will be held accountable to meet them as a condition of receiving the enhanced match, should be added to the Final Rule.***
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> ***2. The current cost/benefit analysis required as part of the E&E APD be revised to require states to articulate the additional burden resulting from a state's failure to merge the two E&E systems into a truly integrated one in those cases where the applicant state is unable to do so at the present time. In the approval letter, CMS should specify a time frame by which the two systems should be integrated. We recommend no later than CY 2018 to allow for use of the A87 Exception by human service agencies.***

In today's web-enabled, consumer-friendly, technical environment, facilitation of truly integrated, modernized integrated E&E systems across health and human services can save money for program

participants and taxpayers and improve the customer experience for many who are receiving benefits from two or more such programs.

## Provisions of NPRM

### §42 CFR Part 433.111 (b): Definitions of Mechanized Claims Process and Information Retrieval System

This section proposes to amend the definition of mechanized claims processing and information retrieval systems to include both MMIS and E&E and also proposes new definitions for "open source" software, "proprietary", "shared services", "MMIS Module", and "Commercial Off the Shelf" (COTS) software.

**APHSA agrees** with the proposed definitions for "open source", "proprietary", and "shared services." We do, however, recommend the following:

- The MMIS Module definition should be reworded to say that it "refers to a group of MMIS business processes that can be implemented through a collection of ***IT functionality or services*.**"

- **Relative to the definition of COTS, we recommend CMS include software specifically designed FOR public assistance programs. It strikes us as highly counterintuitive that such software not be allowed under this rule, and that software specifically NOT designed for public assistance programs would be. This is nonsensical and will only lead to keeping highly useful COTS products out of the H/HS market and/or cause vendors to manipulate their products in such a way as to price themselves out of the market due to unnecessary and costly modifications to fit the inclusion of this counterintuitive rule within the COTS definition.**

**APHSA recommends** for two new definitions to be included in the final rule further clarifying what is meant by "seamless coordination and integration" and "key personnel". To that end, we recommend including:

> **6) "Seamless coordination and integration" is needed. This is one of the review criterion specified later in this NPRM. The term needs to be clearly and uniformly defined here. A number of states have told us they have been subject to different interpretations of what is meant by "seamless" depending upon the Region where they are located or the CMS reviewer they were assigned.**
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> **7) "Key personnel" is needed. As it is included as a new additional requirement in the APD, it should be defined here.**

### §42 CFR 433.112(b) – New Conditions for Mechanized Claims Processing and Information Retrieval Systems

CMS proposes to clarify and add new conditions for Mechanized Claims Processing and Information Retrieval Systems to receive the enhanced FFP for DDI and M&O. APHSA commends CMS on expansion of these conditions to ensure systems are being built to maximize investments being made, and **provide the following recommendations for consideration:**

- "Seamless coordination and integration with the Marketplace, the Federal Data Services Hub, and allows for interoperability with Health Information Exchanges, public health agencies, human services programs, and community organizations;"

  **APHSA recommends CMS specify the review criteria for how the interoperability requirement is to be satisfied. In addition, as mentioned above, the terms "seamless coordination and integration" should be defined.**

- "E&E systems must have acceptable MAGI-based system functionality, demonstrated by performance testing and results based on critical success factors, with limited mitigations and workarounds;"

  **APHSA requests clarification on how CMS will determine acceptable MAGI-based system functionality. We recommend that CMS define criteria in written guidance. Because CMS is having states conduct PERM audits to verify they are doing MAGI eligibility correctly, acceptable criteria needs to be defined, perhaps as part of the PERM audit work currently under way. Regardless, specific criteria should be defined and widely published to take the uncertainty out of the process for the states.**

- "Submit plans that contain mitigation strategies for reducing operational consequences of failure to meet applicable requirements for all major milestones;"

  **We recommend CMS identify the elements of a mitigation they believe to be at least minimally acceptable to their reviewers so that states know ahead of time what is expected. Examples of approved mitigation strategies would be useful as well.**

- "State must identify in the APD key state personnel by type and time commitment;"

  **APHSA requests clarification of how CMS is defining "key personnel"? See recommended 7) definition above.**

- "Systems and MMIS modules developed, installed or improved with 90 percent match must include documentation of components and procedures such that the systems could be operated by a variety of contractors or other users;"

  **This statement unfortunately will appear to be ambiguous and vague to the general reader. States tell us that in reality, documentation and procedures alone are not enough for another vendor to take over maintenance and operations of a MMIS or IES. To that end, most states and vendors today already put together a large amount of documentation. But what, specifically, does CMS believe is critical in order to achieve this very worthwhile goal with which states concur? We recommend for this**

**to be clearly articulated in regulation so that states can require it of their vendors in the RFP process and throughout the build.**

- "For software system & MMIS modules developed, installed or improved with 90 percent match, state must consider strategies to minimize costs and difficulty of operating software on alternative hardware or operating systems;"

  **While APHSA agrees with the concept, CMS should articulate in regulation what the minimally acceptable criteria are that CMS will use to review and approve such strategies. Most states, for example, identify standard platforms through their technical requirements in which the software must run on. Is this acceptable? If not, what is?**

## §42 CFR 433.112(b)(20) and (21): Reuse

Adequate documentation so that software developed with 90 percent FFP can be operated by other users must include clear evidence that this is the case, not left to the discretion of a state or, its contractor with a vested interest in not sharing the software at no additional cost. **We recommend CMS provide examples of acceptable evidence.**

The issue is not so much one of running the software on other hardware and software but, rather, how best can CMS and the states break the long-standing transfer model by which system integrators make hundreds of millions of dollars transferring systems and "configuring" them. CMS and other federal partners should be promoting the leveraging of investments made within states. Once a state invests hundreds of millions of dollars in an eligibility system, most of which are federal tax dollars, that system (or its components) should be leveraged for other systems.

**We recommend** that CMS create a federal/state/industry task force to break this unfortunate cycle of unnecessary spending by including contractors who share such a goal with the states and the federal government.

## §42 CFR 433.112(c): On-going 90 Percent Federal Financial Participation Match Rate

**We support** CMS' proposal to provide the 90 percent FFP to the DDI activities of E&E systems on an ongoing basis. To ensure systems are integrated by 2018, **we recommend** that CMS clearly articulate review criteria with which to evaluate states' progress toward that integration, justifying the continued match rate of 90 percent.

## §42 CFR 433.112(c)(2): COTS

**We strongly support** providing the enhanced match for the development of COTS as well as for its installation. The current situation of providing a lower match (75%) for COTS development has disincentivized companies from pursuing COTS development. **APHSA agrees** that customization of

COTS should not be encouraged since, by definition, the resulting product is not commercial-off-the-shelf software but, instead, customized one-off solutions.

Rather than not providing enhanced match for COTS development, **we recommend** that the definition of COTS allow for software specifically developed for public assistance programs, as well as software developed for other purposes, and rigorously enforced by CMS such that any product that meets that definition qualifies for the enhanced 90% FFP. With regard to customization of COTS, this should be allowed and expected but enhanced match for such customization should be kept to less than 50% of the total COTS development and implementation. CMS should not be discouraging COTS development but ensuring that CMS' funding policies are based on clearly defined definitions of what COTS is, and then paying to support its development and use.

### -Royalty-free license to the Federal Government

Rather than compelling the states to affirmatively maintain and make available the software described in this section of the NPRM, APHSA believes it makes more economic sense for CMS to be the custodian of this information. States do not have the time, staff, or technical resources to undertake this critically important function. It is CMS' responsibility to enforce the regulations at 45 CFR 95.617(b), not the states, and it can only do this effectively by creating a central repository under its immediate control. While it will require additional staff and resources regardless of who has this responsibility, it will cost the states and CMS much more (with the federal match to all of the states) to duplicate this activity 51 times than doing it one-time, centrally in a nationally-coordinated manner.

Given CMS' annual investment of $2-3 billion annually in such IT systems nationally in the Medicaid program, investing only a small percentage of that amount to enforce the federal requirement for royalty-free IT software only makes prudent fiscal sense.

### §42 CFR 433.116: Modular Certification of MMIS

CMS proposes to allow 75 FFP for operations be allowed for certified MMIS modules rather than only when the entre MMIS systems is completed and operational. As CMS is proposing to move to modular certification aimed to further promote reuse and to expand the availability of open source solutions and use of shared services, **APHSA supports** a modular certification process similar to the gate review process states go through for their IES system. Unfortunately, it appeared to states that CMS did not have an intentional, pre-developed process for these reviews. The certification process should be thorough with review criteria shared widely so that the process is a win-win for both CMS and the states.

To the extent that states will define modules/components differently, it will be difficult to establish review and approval criteria for modular MMIS certification by CMS. **We recommend** CMS consider a federal/state task force or other entity to work on this issue.

**APHSA requests** CMS to consider having vendors propose modules for CMS certification prior to state installation. This is what ONC did for EHR systems. Their certification resulted in vaporware being certified. **We agree** with this proposed model provided that the proposed module is not so customized as to be useless to other users across the country. **We recommend** that CMS look at ONC and their missteps in order not to duplicate them with regard to MMIS certification of interoperability.

Additionally and while we understand that approval for E&E system investments must be provided beforehand in order to be eligible for the enhanced FFP and as such, the MMIS system certification requirements are not applicable at this time, **APHSA recommends** CMS, FNS & ACF develop and include performance indicators to measure the interoperability requirements so the states and the federal agencies have a process to validate the completion and operationalization of the shared services being leveraged. These new performance indicators would be included as part of the current Systems Development Life Cycle and gate reviews for E&E systems planning and DDI.

CMS is also proposing to provide 90 percent FFP for the DDI of such mechanized claims processing and information retrieval systems for COTS software when that is a more economical and efficient approach[1]. When seeking an appropriate balance when approving enhanced FFP for the acquisition of open source and propriety COTS software and information technology solutions provided in the Medicaid IT marketplace, **APHSA's concern** is that by using the definition of COTS software as proposed in this regulation requires the state to own or lease the software. We are also concerned that Software as a Service has not been included within the definition of COTS software. Has this been defined elsewhere? Is SaaS acceptable? If so, **we recommend** it should be included in the definition of what is acceptable for a COTS product.

**Additionally, APHSA recommends** CMS certify COTS or open source modules/solutions that states could then leverage within their systems to maximize CMS' and the states' ability to share and reuse IT solutions ultimately ensuring appropriate incentives in the marketplace to provide high quality and valuable IT solutions.

## § 42 CFR 433.116 (j) – Maintenance & Operations

**We commend** CMS for this proposed change from allowing only workers maintaining and testing the actual system to receive the 75 percent FFP for M&O to its availability for all workers who touch the E&E system for Medicaid purposes, including eligibility workers.

Given the significance of this change from past practices, we recommend CMS issue written clarification of this proposed availability of 75 FFP for M&O. In addition, will this change also include support staff, appeals staff, etc. who are not eligibility workers, but are part of the Medicaid process? **We recommend** CMS to clarify this scope in the Final Rule.

The NPRM states it is CMS' intention to "work with the states to do regular automated validation of accurate processing and systems operation and performance". **We recommend** that the Final Rule should clearly specify what the criteria are for these reviews. If these criteria are changing as a result of including E&E systems within the definition of MMIS, will only new systems beheld to these yet-to-be-defined standards? Or will all systems be expected to meet them? And, if so, by when?

[1] Acknowledging though, that it would necessitate an exemption of COTS software to protect intellectual property.

### §433.120 (a) and (b): Disallowance

While APHSA favors the approach CMS has proposed in §433.120(a) and (b), **we are concerned** it will be difficult for states to identify the costs associated with a specific module/component.

### §45 CFR Part 95 – General Administration – Grant Programs, Subpart F

**We commend** CMS for proposing to align the thresholds acquisition costs for E&E systems to that of MMIS.

As states aim to meet the Interoperability Condition for E&E systems allowing for connectivity to human service programs, **APHSA recommends** CMS, FNS and ACF issue further clarification and guidance on how the acquisition thresholds for integrated E&E systems align across the three agencies. As noted in our comments on CMS-10536, Medicaid E&E IAPD Template around the Supporting Statement for Paperwork Reduction Act Submissions-Part A, Section B (1), it would be beneficial to the states for the agencies to make explicit the acquisition thresholds across the agencies approving E&E APDs.

It would also be helpful to clarify expectations and processes by which this information can be used in the future by the respective agencies/departments in an effort to reduce duplication and other barriers that stand in the way of more cost-effective use of federal and state tax dollars for purposes of DDI of integrated E&E systems.

**We recommend** ACF, FNS & CMS issue written guidance and clarification on both cross-programmatic acquisition thresholds and expectations and processes by which this information can be used moving forward.

### Conclusion

Generally, we agree with the direction CMS is proposing in this rule for Medicaid Mechanized Claims Processing and Information Retrieval Systems. We believe they will enhance modernization efforts of MMIS, E&E DDI and M&O, and ultimately reduce costs and duplication. We continue to believe that the real savings will come from a single health and human service integrated system in the states that truly leverage this match and the A-87 Cost Allocation exception.

APHSA appreciates the opportunity to provide comments on provisions of this proposed rule. Streamlined, modern IT systems spanning across programs that serve the same populations and save taxpayers' dollars are extremely important to our members. We look forward to working with you on these and other issues and appreciate your time and consideration of these comments. Please contact Megan Lape with any questions at (202) 682-0100, x265 or mlape@aphsa.org.

Sincerely,

Tracy Wareing Evans
Executive Director, APHSA