



January 7, 2010

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2346-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities

Dear Sir or Madam:

I am writing on behalf of Molina Healthcare, Inc. (MHI) to offer comments in response to the "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities" proposed rule. The proposed rule was published in the Federal Register on November 8, 2010 (75 Fed. Reg. 68583).

Since 1980, Molina Healthcare has been a leader in providing quality healthcare to those who depend on government assistance. Our commitment to our members has made us a national leader in providing affordable healthcare to families and individuals. We work with Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to provide healthcare assistance to approximately 1.5 million members in eleven states.

This year, Molina Healthcare Inc. acquired Health PAS, and formed Molina Medicaid Solutions (MMS), a subsidiary of MHI. Health PAS is a new, high-performance, real time Medicaid management information system (MMIS) that adapts quickly to regulatory and marketplace changes and meets all functional and performance requirements of the modern Medicaid system. Health PAS is the only commercial-off-the-shelf (COTS) software-based, Medicaid Information Technology Architecture (MITA) aligned, certified MMIS in the country and provides the advanced problem solving capabilities that are needed today.

Through Health PAS, and other software products, Molina Medicaid Solution serves as the fiscal intermediary for the Medicaid programs in New Jersey, Louisiana, West Virginia, Idaho and Maine. Each year, MMS processes over three hundred million healthcare claims, making payments to over two hundred thousand providers for four million people, issuing more than \$24 billion in benefit payments.

Molina Healthcare, Inc. • P.O. Box 3396, Baton Rouge, LA 70821
225-216-6000 • Fax: 225-924-6179

The proposed regulation is critical to the success of health care reform. With the passage of the Patient Protection and Affordable Care Act (PPACA), MMIS transformations will be needed in most states. The majority of Medicaid systems throughout the U.S. are based on the original Medicaid systems created in the late seventies and early eighties. Though they have had numerous enhancements and are customized to each state, the basis of the original system is still largely present. States will need to apply new rules to adjudicate eligibility for the program, enroll millions of newly eligible individuals through multiple channels, renew eligibility for existing enrollees and operate seamlessly with newly authorized Health Insurance Exchanges.

Molina is pleased to offer the following recommendations on this important regulatory proposal that truly connects the entire healthcare industry.

Medicaid Eligibility Determination

Historically, Medicaid eligibility for many applicants and recipients was determined by an agency other than the state Medicaid agency. This regulation proposes to “consider Medicaid eligibility determinations to be “claims” of eligibility that can be considered part of the MMIS systems that are potentially eligible for the enhanced 90 and 75 percent FFP.” CMS expects that changes to state systems will be completed with the start of the new ACA provisions and support the operation of Exchanges on January 1, 2014.

State agencies currently struggle with the interfacing data between their Eligibility Determination systems and the Medicaid Management Information Systems (MMIS). This is due primarily to how data is defined differently across functions and within the two types of systems. For example, Eligibility Start Dates, Household Case Definitions and Special Programs may be data elements used by various systems but with very different meanings. Additionally, eligibility for Food Stamps and Temporary Assistance for Needy Families (TANF) is generally household driven, while Medicaid determines and pays claims based on individual members of a family or household. These types of issues will only be further exacerbated with the addition of health insurance exchanges. It would be helpful if CMS provided additional leadership and technical assistance in further standardizing data semantics and information nomenclature across the Eligibility function.

With over 30 years of experience managing care for low-income populations, combined with Health PAS, our cutting-edge and customizable technology, we feel we are uniquely positioned to partner with states to meet more of their Medicaid needs. We understand the population, the complexities of the Medicaid program, and the unique needs of each state. Further, we recognize the fundamental role that the eligibility determination system will play in the Exchange. Molina prides itself as being a “Medicaid solutions” partner and supports this proposal to consider Medicaid eligibility determination to be part of the MMIS system.

Transforming systems as complex and far-reaching as the MMIS within the specified timeframes will be challenging. It would be helpful if CMS produced and made available to the states a project-planning template illustrating key entry points to major phases of the projects. Its use could be optional, but there is not much time for “re-work”, so this type of technical assistance and affording states additional time for planning may be warranted.

In almost every state, the funds to modernize the MMIS will need to be approved through the legislature. Since this rule will likely not be finalized until the middle of 2011, some states may not approve the funding until 2012, giving them just one full year to procure an eligibility determination system. Although Health PAS is unique in that it is highly adaptable and customizable, CMS knows first hand that the many moving pieces and technical details take time to work through.

In addition, there are many other program changes on the horizon, including Provider Incentive Payments and ICD-10 changes that will also require complex system changes in many states. It is not time or cost effective for states to procure these additional capabilities on a piece-meal basis. States are on the brink of a major health IT implementation project that puts billions of dollars and millions of lives at stake. States need to be thoughtful, calculated and strategic and will take their time to make the right decisions.

The enhanced Federal financial participation (FFP) funding is crucial to the timely implementation of Medicaid eligibility determination systems. We fully support increasing the FFP to 90% through the end of 2015, and will work closely with the states to help them understand the program changes and transform their systems. Although most changes to the system will be completed by January 1, 2014 to support the operation of the Exchanges, there will inevitably be fixes along the way. By providing an additional 2 years of 90 percent enhanced FFP, states’ systems will have additional time to ensure they are at peak performance.

Standards and Conditions to Receive Enhanced FFP for Maintenance and Operations

In addition to eligibility determination, the proposed regulation lays out a set of seven standards and conditions that states must commit to in order to receive enhanced FFP at 75% of expenditures for maintenance and operations. Molina developed the Health PAS tool with many of these same objectives in mind, and therefore supports imposing these standards and conditions on states as a prerequisite to receiving enhanced FFP.

1) Use of a modular, flexible approach to systems development

As the program needs change, the configurability of Health PAS allows rapid design and implementation of changes without costly and time-consuming source code modification.

2) Measurable progress in implementing their MITA

Health PAS is the only COTS software-based, MITA aligned, certified MMIS in the country.

3) Ensure alignment with, and incorporation of, industry standards

Health PAS is fully compliant with the Health Insurance Portability and Accountability Act (HIPAA), including the ability to handle the ICD-10 code sets.

4) Promote sharing, leverage and reuse of Medicaid technologies and systems within and among states

The Health PAS software is sufficiently flexible to meet different needs and perform different functions that result in cost savings. As a multi-state organization, we have the experience of sixteen different Medicaid markets to share best practices.

5) Support accurate and timely processing of claims including claims of eligibility, adjudications, and effective communications with providers, beneficiaries, and the public

The Health PAS Administrator component furnishes the core MMIS functionality to support a state's Medicaid program including maintaining provider, member and reference data as well as configurable rules for processing and adjudicating claims, encounters and prior authorizations. We look forward to adding the eligibility capability to our suite of solutions to meet the changing needs.

6) Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement

The Health PAS Analytic component provides a broad array of powerful data analysis and data mining tools with a fully integrated data warehouse and a separate data mart for Management and Administrative Reporting System

(MARS), Surveillance and Utilization Review System (SURS), and Executive Information System (EIS) functionality. These tools provide state-of-the-art capabilities in querying, reporting statistical analysis, provider profiling, geographic information system (GIS), fraud and abuse protection, and management and administrative reporting.

7) *Ensure seamless coordination and integration with the Exchange*

MMS is committed to providing states the solutions they need to be in compliance with the ACA.

Reviews and Performance Monitoring

Previously, CMS reviewed each state system at least once every 3 years, and, based on the results of the review, reapproved it for FFP at 75 percent if the standards and conditions were met. As part of System Performance Reviews (SPRs), CMS determined if the system program logic was accurately and timely processing claims and payment information. Subsequent recertification of a state's MMIS was based upon the results of the SPR. CMS stopped performing such reviews with the passage of the Balanced Budget Act (BBA). While the BBA eliminated CMS' mandate to perform SPRs, it did not remove their discretion to perform reviews under general authority to ensure that MMISs continue to operate in a manner that complies with federal law, regulations, and guidance.

This regulation proposes to replace SPRs with periodic reviews of the MMIS by the Secretary. We support this proposal and look forward to sub-regulatory guidance as to how CMS will measure whether the requirements are being met by the states. CMS has already stated that interoperability with other federal and state health programs will be a critical component of the review process.

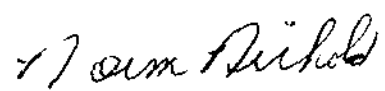
Partial Systems Improvements or Modernizations

Many states may choose to improve and modernize their systems in phases. CMS is proposing that states submitting partial system updates would need to submit and have an approved roadmap for achieving full compliance with the standards and conditions in this regulation. As noted above, we feel that states have reached a tipping point since the resources are there, the technology is available, and all levels of government are pushing for adoption. While a phased approach to implementing systems is appropriate, we agree with CMS that this approach can only be successful if states have an approved roadmap for achieving full compliance.

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Thank you for your consideration. We appreciate the opportunity to comment on these important regulatory proposals.

Sincerely,

A handwritten signature in cursive script that reads "Norm Nichols".

Norm Nichols
Chief Operating Officer
Molina Medicaid Solutions