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

SMD# 16-004

RE: Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding

March 31, 2016

Dear State Medicaid Director:

This letter provides guidance concerning the enhanced federal match rate, and other federal match rates, for various activities related to Medicaid Information Technology (IT) in both Medicaid Management Information Systems (MMIS) and Medicaid Eligibility and Enrollment (E&E) Systems, including the use of Commercial Off-the-Shelf (COTS) software. This guidance is set out in the letter itself and the appendices, which include answers to frequently asked questions.

On December 4, 2015 the Centers for Medicare & Medicaid Services (CMS) published a final rule, "Mechanized Claims Processing and Information Retrieval Systems (90/10)," which became effective January 1, 2016. This final rule extended enhanced federal funding for Medicaid eligibility and enrollment systems and revised the conditions and standards state Medicaid IT systems must meet to qualify for enhanced federal funding to better support Medicaid eligibility, enrollment, and delivery systems. This final rule also supported existing requirements for modular systems development. This guidance reflects input from commenters in the rulemaking process, our state partners and other stakeholders.

Background

The recently issued final rule made permanent the applicability of enhanced federal matching rates under section 1903(a)(3) of the Social Security Act (Act) to support the design, development and installation (DDI) and maintenance and operations (M&O) of E&E systems that are streamlined, interoperable with other systems and that provide a consumer-friendly experience. The enhanced federal matching rate is applicable under section 1903(a)(3) to, "mechanized claims processing and information retrieval systems." The final rule amended the regulatory definition of such systems at 42 CFR 433.111(b) to include E&E systems. The broadened definition of such systems, and additional changes made in the applicable requirements for such systems, supported an enterprise approach where individual processes, modules, sub-systems, and systems are interoperable and work together seamlessly to support a unified enterprise.

The enhanced federal financial participation (FFP) for E&E systems will ensure that states have the resources necessary to complete and maintain updated IT systems. We anticipate states will use these resources to further integrate with Marketplace systems and human service program systems, while retiring outdated legacy systems. CMS expects that up-front investments in the newly developed systems will reduce long-term costs due to the technological efficiencies that will provide an enhanced consumer experience.

This final rule provides for an FFP rate of 90 percent for state expenditures for DDI of Medicaid solutions that include COTS, subject to review and approval by CMS. We believe that the use of modular development provides the most efficient and cost-effective long-term solution for states' business needs. Modular development may include COTS products or Software-as-a-Service (SaaS) solutions as well as other modular approaches.

Conditions for Receipt of Enhanced Rate of FFP for Medicaid E&E Systems

The conditions specified in § 433.112(b) apply to Medicaid E&E systems. Medicaid E&E systems are also subject to the Medicaid Information Technology Architecture (MITA) conditions and standards, and must meet Critical Success Factors (CSFs) and other performance standards to qualify for the enhanced match rate. See: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf.

Reimbursable Activities and FFP Rates for Medicaid E&E Systems

The federal matching rates for Medicaid E&E systems are the same rates applicable to the other component of mechanized claims processing and information retrieval systems, the MMIS. Those matching rates are 90 percent for DDI and 75 percent for M&O. Below are examples of activities that would qualify for each enhanced match rate. These examples are meant to clarify the final rule and provide guidance to states.

Examples of activities that qualify for 90 percent enhanced rate of FFP include:

- Planning activities, including impact assessments, gap analyses, proof of concepts, requirements analyses (functional/business and technical), and any preparation activities necessary for the implementation/administration/operations;
- Performing a MITA State Self-Assessment (SS-A);
- Interfaces and establishing connectivity (e.g., system to web-based portal);
- Integration and configuration activities to interact with software solutions or applications;
- Preparation and development or enhancement of contingency plans, business continuity plans, disaster recovery plans and security plans;
- Initial software leasing/licensing (including SaaS and COTS); and
- Configuration and minimal customization of COTS software.

Examples of activities that qualify for the 75 percent enhanced rate of FFP include:

- System and/or software maintenance (in-house and/or contract);
- Web-based portal and technology maintenance (in-house and/or contract);
- System(s) and web-based portal operation (in-house and/or contract);
- On-going software leasing or licensing;
- On-going proprietary software leasing or licensing; and
- Training of personnel directly engaged in the operation of a system, including workers processing claims or determining eligibility.

Please refer to Appendix A- *List of Reimbursable Activities and Eligible Federal Financial Participation Rates* for an updated list of activities and corresponding match rates. Refer to Appendix B- *M&O Rates for Medicaid E&E Systems* for more detailed information specific to FFP rates for Medicaid E&E systems activities.

Enhanced FFP for COTS Software and Commercially Available Hosted Solutions
States are encouraged to use existing software, such as COTS and commercially-available hosted solutions (e.g., SaaS) in their Medicaid IT solutions where such use can be shown to be efficient and economical in comparison to other alternatives. "COTS software" means specialized software (which could be a system, subsystem or module) designed for specific applications that is available for sale or lease to other users in the commercial marketplace, and that can be used with little or no modification.

The Medicaid Information Technology Architecture (MITA) model encourages states to move to standardized, service-oriented COTS products and away from the kind of heavily-customized solutions that were common in the past. COTS software, if not overly-customized, supports modularity and enables other states to leverage successful solutions. A modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces (APIs) facilitates the separation of business rules from core programming. We are encouraging states to make their business rules available in both human and machine-readable formats to further facilitate sharing. MITA requires state solutions to promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states.

While preference will not be given to COTS software over other MITA-compliant solutions (such as open source technologies or cloud-based services), CMS promotes consideration of COTS products and SaaS solutions as options for states pursuing development of Medicaid IT systems leading to more efficient, economical, and effective State Medicaid Plan administration.

CMS will review APDs that propose use of the enhanced FFP match for COTS products and commercially-available hosted solutions to determine whether the proposed solutions are more efficient and economical than other available alternatives. These solutions may be employed for full systems or for specific modules or components within a system (e.g., business rules engine,

notices subsystem). The costs of COTS software implementation which are eligible for enhanced funding include:

- At the 90 percent federal matching rate -- the initial licensing fees, and minimum necessary costs to analyze the suitability of COTS or hosted software, installation, configuration and integration of the COTS or hosted software solution, and modification of existing state software to ensure interoperability and coordination of operations.
- At the 75 percent federal matching rate -- ongoing licensing fees during M&O, including usual and customary charges for routine software updates or upgrades, and any associated modifications to customization that might be required.

Use of COTS or SaaS as Efficient and Economical

To document that the use of COTS or a commercially available hosted software solution is efficient and economical, the APD should explain the benefits to the project in terms of minimizing time and costs to implement and make improvements to operations, as well as lower long-term maintenance and operations costs. The APD analysis of these benefits should include a comparative analysis of alternatives. The purpose of the alternatives analysis is to show why the proposed solution results in the most efficient and economical choice for the Medicaid program, compared to other potential solutions. This analysis should be sufficiently clear to support an audit or other oversight review. The analysis should contain data relative to "cost of ownership" and "return on investment" considerations and also include long-term costs to be incurred during M&O. The state should also discuss their decision whether the use of a particular solution will result in any dependencies that create a "lock in" for future procurements. Such dependencies are in conflict with imperatives for modularity and interoperability.

The benefit of COTS or SaaS is that it provides sufficient capabilities so that modification for the intended use is straightforward. Software and hardware solutions must be selected based upon the capabilities and requirements identified during the DDI phase of the project. In instances where multiple solutions exist, only those modules which address defined requirements should be selected. The software which meets the highest number of technical function points without modification of the commercial code is typically the optimal technical solution, although the total cost of ownership must be taken into account. A gap analysis is useful to understand the extent to which a given COTS or SaaS product meets functional and technical requirements.

Configuration and Customization of COTS Software

Regulations at 42 CFR § 433.112(c)(2) provide that COTS-related development costs at the enhanced match rate may only include the initial licensing fee and the minimum necessary to install, configure, and customize the COTS software and ensure that other state systems coordinate with the COTS software solution. When responding to a request for the 90 percent FFP rate for a COTS product, CMS will consider whether the configuration and customization of the product would be kept to minimal levels to achieve full functionality in the most cost-effective manner.

Configuration and testing may be required as part of the DDI phase of systems development to ensure the COTS software performs correctly within the state's Medicaid environment. Configuration pertains only to the functionality included in the core software or complimentary software or applications designed specifically to work with that solution. It does not require modification of any of the underlying source code for the COTS software itself. Examples include population of reference data, setting of parameters, definition of business rules, and work flow settings. COTS software configuration costs are matched at 90 percent.

A condition for enhanced funding of COTS software is that customization of the product is minimal. Examples of minimal customization include modification of database interactions to include additional required data elements, processing of state specific but necessary business rules, and modification of interfaces to allow interoperability with existing systems or modules. If a COTS product is heavily customized, then the solution may become so unique to that state that other states are unable to reuse it, or that newer releases of that software cannot be easily integrated into the state's system, resulting in a solution that no longer meets the MITA conditions.

For each project incorporating COTS software the APD should include the following:

- Clearly delineated costs for configuration and customization;
- Detailed description of the configuration of the COTS product for the proposed installation;
- An outline of customization for the COTS solution, including high-level activities and their associated costs; and
- Description of cost allocations of COTS products between DDI and M&O. Significant enhancements or new functionality may be considered DDI subsequent to release of a system to M&O, only if adequate justification is provided.

Ownership and Royalty-Free Licensing

COTS products and SaaS solutions are designed, developed, and licensed by the vendor, so the state is not entitled to ownership rights to the core program. When the enhanced match is used for COTS configuration or customization, those elements become subject to existing regulation at 45 CFR § 95.617 regarding state and federal ownership and royalty-free licensing. The requirement for a royalty-free, non-exclusive and irrevocable license to software referenced in 45 CFR § 95.617(b) applies only to the software related to the customization and configuration of a COTS product for state use and does not apply to the core product. This means that states could freely share and reuse the resulting COTS software configuration and customization, subject to licensing of the core COTS software products. Contract documents submitted pursuant to an approved APD must clearly specify what is being reused or shared.

This SMDL supersedes and takes precedence over previous guidance in the State Medicaid Manual (SMM) 11100 through 11281 (https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html) with respect to

Medicaid E&E systems and certain other reimbursement rules, until such time as the SMM is updated. The appendices to this letter include additional detail on these topics.

If you have additional questions, please contact Martin Rice at 410-786-2417 or at martin.rice1@cms.hhs.gov. Additional SMDLs will be issued in the coming months to address other aspects of this final rule. We look forward to working with states to facilitate state system builds, to ensure compliance with this regulation, and to provide assistance implementing these requirements.

Sincerely,

/s/

Vikki Wachino
Director

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

Appendix A

List of Reimbursable Activities and Eligible Federal Financial Participation (FFP) Rates

Related Activity, Scope, Content and/or Definition	FFP Rate
Section1: Planning	
Contractor services	90%
Facility and equipment (i.e., work spaces, software tools, etc.)	
Meetings directly tied to system planning	
Participation in workgroups directly tied to system planning	
Planning, including impact assessments, gap analyses, proof of concept activities, requirements analyses (functional/business and technical), and any preparation activities necessary for the implementation/administration/operations	
Preparation and development of the APD, RFP, and other related procurement instrument(s) for the implementation, enhancement, and/or operation phase	
Preparation and development of the related planning Request for Proposal (RFP) for vendor and consulting services	
Procurement and acquisition (i.e., solicitation, evaluation, negotiation, contract selection, etc.)	
RFP-related services contract	
State personnel directly engaged in planning activities	
Travel directly tied to planning	
Section 2: Implementation	
User Acceptance testing	90%
Contractor Services for DDI	
DDI activities	
Data conversion when transitioning from one system to another	
Hardware, equipment and supplies for DDI (prorated between DDI and M&O)	
Facility for DDI (prorated between DDI and M&O)	
Initial software leasing/licensing	
Integration/configuration activities including business process engineering to install a COTS and/or SaaS and/or hosted solution	
Procurement of new releases of COTS products that were matched at 90%	
Interfaces and connectivity	
Development and/or update of state-owned database and/or software to facilitate conversion of data format	
System integration/interfaces with Medicaid E&E system and/or MMIS	

Section 2: Implementation, continued	
Independent Verification and Validation (IV&V) services contract	90%
Installation, reconfigurations and/or modifications of transfer systems necessary to meet state specific requirements, including testing, data conversion, system stabilization (see above for other implementation activities eligible for 90/75/50 rates)	
Approved customization of COTS software	
Participation in workgroups directly tied to system implementation	
Preparation and development of the implementation APD, RFP, and other related procurement instrument(s) if applicable (i.e., no planning phase APD performed)	
Preparation and development/enhancement of contingency/business continuity/disaster recovery/security plans.	
Procurement and acquisition (i.e., solicitation, evaluation, negotiation, contract selection, etc.)	
Project Management/Quality Assurance services contract	
Site preparation	
Software tool(s) for DDI	
State personnel directly engaged in DDI	
DDI on Asset Verification Systems (AVS)	
Travel directly tied to system implementation	
Documentation and publications (i.e., creation of training for users and business partners)	75%
Ongoing software leasing/licensing only for system integration and configuration activities.	
Ongoing hosted solution costs only for system integration and configuration.	
Configuration and/or update of cloud-hosted database	
System User Training (directly tied to system usage)	

Section 3: Maintenance & Operations (M&O)	
Call center, i.e., customer/provider relation functions (in-house and/or contract) directly related to systems operation (issues related to eligibility determination/maintenance and claims processing).	75%
Costs of the Operations environment	
Facility and equipment (direct non-personnel costs, i.e., work spaces, software tools, etc.)	
Hardware update purchase/lease for operations	
Ongoing proprietary software leasing or licensing including COTS/SaaS	
Ongoing repetitive cyclic conversion of data	
Production of notices, reports, including MARS and SURS documents, or Medicaid/CHIP ID cards, including eligibility letters, EOBs, Form 1095Bs, 1099s, Remittance Advices etc.	
Provider outreach and training related to systems operation (for example, training on claims submissions, claims processing, and eligibility inquiries).	
Publications necessary for the operation of the system, i.e., paper application, user manual, etc.	
System and/or software maintenance (in-house and/or contract)	
System(s)/Web-based Portal operation (in-house and/or contract)	
Training of personnel directly engaged in the operation of an approved system, including workers processing claims or determining eligibility	
Salary, fringe and other direct costs for personnel engaged in determining eligibility, as specified in Appendix B.	
Regular Program Administrative Costs (i.e., audit)	50%
End-user/Business User training for personnel NOT directly engaged in eligibility determinations	
Facility and equipment (indirect non-personnel costs, i.e., work spaces, software tools, etc.)	
Indirect personnel costs	
Postage	
Section 4: MITA	
In-house and/or contractor to perform a Medicaid enterprise MITA SS-A	90%

Appendix B

M&O Rates for Medicaid E&E Systems

E&E Activities Matched at 75% FFP

Application, On-going Case Maintenance, and Renewal activities including line staff, supervisory staff and support staff for the following:

- **Intake**- Application/data receipt and activities related to receipt of the application or data related to applications.
- **Acceptance** - Edits, verification and resolution of inconsistencies- Manual and automated edits and verification of data.
- **Eligibility determinations -** Activities related to utilizing the automated eligibility determination system in the evaluation of the edited, verified data to make an eligibility determination.
- **Outputs** - Issuance of eligibility notices to the customer, file updates and transactions to partners, such as the Federally-Facilitated Marketplace (FFM), State Based Marketplaces (SBMs), Managed Care Organizations (MCOs), Point of Sale (POS) vendors, etc. Mailing of notices is matched at 50 percent.
- **On-going case maintenance -** Includes intake activities related to renewals and receipt of data related to the ongoing-eligibility and maintenance of a beneficiary's eligibility, such as address changes, income changes, and household composition changes. Does not include verification activities that occur after enrollment.
- **Customer service -** Call center activities related to receipt of data required for an initial eligibility determination and the ongoing-eligibility and maintenance of a beneficiary's eligibility, but not verification activities, as described above. Costs of call center staff are eligible at the 75 percent rate only for activities related to eligibility determination or on-going case maintenance.

  Those call center functions related to benefits, general beneficiary education, plan choice and enrollment are eligible at the 50 percent FFP level. Costs of call center staff should be allocated based on the portion of staff time spent performing functions eligible at the 75 percent rate versus those eligible at the 50 percent FFP levels.
- **Maintenance and Routine Updates -** Routine system maintenance, security updates, automated re-running of eligibility based on updates of standards and program rules, and other routine maintenance activities related to the Eligibility Determination System.

<u>E&E Activities Matched at 50% FFP</u>

Activities which precede the eligibility determination such as outreach, application assistance, etc. and activities subsequent to the eligibility determination such as appeals, reports, etc.:

- **Outreach and Marketing -** Includes general public outreach, beneficiary education and outreach, explanations of eligibility policies, programs and benefits, plan choice counseling and plan enrollment.

- **Policy research and development -** Even if related to the eligibility determination standards and methodologies.

- **Staff development and training -** Even if related to eligibility determination, except for Operational Readiness training for new systems.

- **Community-based application assistance -** Such as assisting with application completion and navigation, etc.

- **Program integrity -** Includes audits and investigations, PERM, MEQC, and any other quality assurance activities.

- **Eligibility verification and validation functions unrelated to the operation of electronic systems –** Includes citizenship/immigration and income verification activities other than electronic data matching operations, and any other administrative verification activities that occur after the individual is enrolled and do not involve any electronic operations.

- **Formal appeals of eligibility decisions -** Includes accepting and processing appeals, and hearings, and decisions if rendered by the State Medicaid Agency.

- **Customer service -** Includes call center activities and out-stationed eligibility worker activities related to areas such as beneficiary education, benefits, plan choice and enrollment, civil rights complaints, appeals.

Appendix C
Frequently Asked Questions and Answers

Q1: How should states report 75 percent Medicaid Eligibility and Enrollment (E&E) system maintenance and operations (M&O) activity expenditures on the CMS-64-10 and CMS-37-10?

A1: The CMS-64-10 and CMS-37-10 forms capture Medicaid E&E systems M&O expenditures. Such expenditures are tracked separately as follows:

- M&O expenditures for Medicaid E&E systems, excluding eligibility workers, are reported on the CMS-64.10 and CMS-37.10 on Line 28C – Operation of an approved Medicaid Eligibility Determination System/Cost of In-house Activities and Line 28D – Operation of an approved Medicaid Eligibility Determination System/Cost of Private Sector Contractors.
- Expenditures for Eligibility Determination Workers eligible for enhanced match are reported on the CMS-64-10 and CMS-37-10 on Line 28E - Eligibility Determination Staff – Cost of In-house Activities and Line 28F- Eligibility Determination Staff – Cost of Private Sector Contractors.
- Expenditures for Eligibility workers eligible at the standard administrative match of 50 percent are reported on the CMS-64.10 and CMS-37.10 on line 28G – Eligibility Determination Staff – Cost of In-house Activities and Line 28 H – Cost of Private Sector Contractors.
- As with all expenditures, federal match must be properly claimed and is subject to review and approval. CMS will work closely with each state to review and approve costs and confirm specific implementation details before states submit claims.

Q2: When can the 75 percent Federal Financial Participation (FFP) rate for M&O for Medicaid E&E systems begin? When does it end?

A2: Eligibility for the enhanced 75 percent FFP rate will be based on state systems being compliant with the Seven Conditions and Standards and meeting minimum CSFs. The enhanced 75 percent FFP rate will be available when the approved system becomes operational but not earlier than October 1, 2013. In order to begin claiming, states must submit an Operational APD Update to CMS that clearly identifies the functions, staff and costs to be charged at the 75 percent FFP level. The Operational APD Update must be approved by CMS before a state can begin claiming the enhanced match. The availability 75 percent FFP rate does not expire.

Q3: Does the 75 percent FFP rate apply to program integrity activities associated with eligibility and enrollment?

A3: No, program integrity activities are matched at the standard administrative match of 50 percent, including activities performed post-eligibility and normally initiated as part of a sampling approach, including audits, Payment Error Rate Measurement (PERM) or Medicaid Eligibility Quality Control (MEQC) activities. Such costs are usually indirect costs, including the staff costs associated with agency-wide functions such as accounting, budgeting, and general administration. The Operational APD Update must include an allocation or distribution plan showing the breakout of direct and indirect costs for equipment, supplies, and non-personnel resources it intends to claim, along with justifications.

Q4: What aspects of the COTS solution will be subject to the requirements regarding royalty-free licensing?

A4: COTS products developed by the vendor will continue to be owned by the vendor since they developed the software without federal funding. Configuration and any customization related to the COTS product installation will be owned by the state as it will have been developed with enhanced DDI funds (90 percent FFP rate). The state and federal government will have a royalty-free license, per 45 CFR 95.617, that allow the sharing of the configuration and customization of the COTS product with other state Medicaid programs. Other states are still responsible for any license fees for the core COTS software product.

Q5: Are lump sum licensing costs eligible for the 90 percent FFP rate?

A5: The initial licensing cost required for installation of the COTS product is eligible for 90 percent FFP. However, such costs may only include licensing for the product during the DDI phase. Licensing costs for use during the M&O phase are matched at 75 percent. Lump sum licensing costs should be allocated over the entire licensing period, and only the portion that is attributable to the DDI phase would be eligible for 90 percent FFP. The remaining costs would be eligible for 75 percent FFP.

The subscription model calls for periodic payments instead of a lump sum payment. It may be preferable when a state does not want to deploy the COTS software within its E&E or MMIS environment, as in a software as a service (SaaS) arrangement. Federal match rates of 90 percent for DDI and 75 percent for M&O will apply equally to COTS and all commercially available software including SaaS.

Q6: What is the definition of "minimal customization"?

A6: The regulation does not include a definition of "minimal customization." Accordingly, CMS will consider each request for the 90 percent FFP rate for COTS solutions individually. When evaluating if the proposed customization is minimal, CMS will consider the cost, size, nature, and scope of the product. It is incumbent upon the state to fully describe and justify the required configuration and customization in the APD to receive approval for the 90 percent FFP rate.

Q7: Does the information in this letter apply to CHIP programs?

A7: The funding described in this letter applies to all Medicaid systems including those that are fully integrated with and support CHIP programs. The enhanced funding does NOT apply to stand-alone CHIP programs that are not fully integrated with Medicaid.

Q8: Is the exception to the cost allocation requirements set forth in the Office of Management and Budget (OMB) Circular A-87, Section C.3 and 2 CFR 200.405 of the superseding "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards" going to be continued permanently, similar to the 90/10 funding?

A8: No, the exception to the cost allocation requirement is not permanent. This exception has been extended only through December 31, 2018. The July 20, 2015 Tri-Agency letter provides details on the extension and can be found at https://www.medicaid.gov/federal-policy-guidance/downloads/SMD072015.pdf.

CMS expects that this extension of the exception to certain OMB cost allocation requirements, along with the permanent extension of enhanced Federal funding for Medicaid systems, will provide states additional time needed to integrate the additional human service programs. However, states must consider the expiration of the A-87 exception on January 1, 2019, and plan future activities and funding accordingly.