



March 15, 2010

Charlene Frizzera
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Ms. Frizzera,

On behalf of Medicaid Health Plans of America (MHPA) I am submitting comments on the Notice for Proposed Rulemaking: *Medicare and Medicaid Programs; Electronic Health Record Incentive Program [CMS-0033-P]*

The Medicaid Health Plans of America is a national nonprofit organization and the leading trade association solely focused on representing Medicaid health plans. MHPA member plans range from large multi-state plans to small community-based plans. The mission of MHPA is to develop and advance public policy that improves access and delivery of quality health care to Medicaid members and improves the efficiency of services.

As of 2008, 36 states and the District of Columbia have contracted with Medicaid health plans to provide benefits to over 21 million enrollees. Our plans have extensive experience in partnering with states to efficiently deliver quality health care in the Medicaid program. MHPA makes the following recommendations and comments:

MHPA supports the EHR Incentive Program and believes it is critical to improving the coordination and quality of care for Medicaid beneficiaries

The Medicaid population struggles with poorer quality outcomes, less access to providers, and a larger share of racial and ethnic health care disparities, than the commercially insured. While Medicaid health plans have made numerous strides in care coordination and improved access, this population stands to greatly benefit from the implementation of HIT. The meaningful use criteria should strongly emphasize the ultimate goal of HIT: improving the quality of care.

Simplify the meaningful use criteria to make it feasible for more Medicaid providers to participate in the incentive program.

Most Medicaid providers work in small practices and have limited staff resources to implement EHR, even with incentive payments. We anticipate that many Medicaid providers will have difficulty meeting all of the currently proposed meaningful use criteria. This may result in the unintended consequence of further limiting access to quality care for Medicaid members who already face access challenges in their communities.

One of MHPA's urban plans reports that small primary care practices, as defined as ten or fewer practitioners, cover close to 50% of their members. Were these practices to fail to adopt EHRs,

it could severely limit Medicaid members' access to providers driving them to utilize higher cost alternatives such as hospital emergency rooms.

- We recommend that CMS reconsider the “all-or-nothing” approach and allow providers to be eligible for incentives by meeting, or demonstrating progress towards meeting, a smaller, yet consistent set of the meaningful use criteria.

Encourage states to create consistent definitions of meaningful use

While we recognize that states are at various stages of implementing HIT programs, inconsistent definitions of meaningful use will pose challenges for health plans operating in multiple states. Many challenges with varying state contractual rules and regulations already exist. Inconsistent expectations will create challenges for entities promoting the adoption of EHR.

- We recommend that CMS continue to move towards standardization and guide states to creating consistent meaningful use definitions. The more standardization across Medicaid programs, there will be more money saved across the health care system.

Provide further guidance on the role Medicaid agencies must play in determining provider eligibility and compliance in the EHR incentive program

Medicaid health plans currently play a large role in today's Medicaid program. There is already significant variation among states in how much responsibility is transferred to health plans to enforce state and federal regulations.

- We recommend that CMS provide clear guidance to states on the role and responsibility of states in enforcing the rules of the EHR Incentive Program.

Provide clarification on rules for pass-through payments to Medicaid health plans for eligible providers and clarify the definition of entities promoting the adoption of certified EHRs

The proposed rule stipulates that any existing state relationships with managed care plans do not result in payments that exceed 105% of the capitation rate to pass incentive payments through to providers.

- We recommend that CMS provide clearer guidance to states on how to implement these pass through payments given that many Medicaid providers contract with multiple Medicaid health plans. This will create additional administrative burden for health plans held responsible for administering pass-through payments.
- We recommend that CMS require states to pass an appropriate amount of administrative payments to managed care plans to cover the additional costs of administering the pass-through payments to providers. We recommend that these administrative payments

should be outside of the 105% rule and that states and NAIC should be prevented from requiring that the pass-through payments be included in health plans' reported gross revenue and in any regulatory calculations that determine reserving levels including risk based capital levels

Further, the close relationship of Medicaid health plans to their provider networks positions the plans to be an effective supporter for providers in their adoption of EHR.

- We recommend that the final rule should clearly indicate that Medicaid health plans qualify as an “entity promoting the adoption of certified EHRs”.

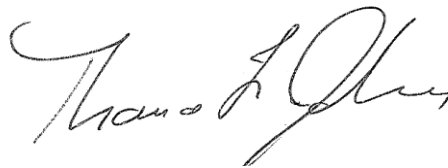
Simplify and streamline quality reporting requirements

MHPA recognizes the importance of performance measurement in assessing the quality of care and improving outcomes, and continue to support the inclusion of quality measure reporting as part of demonstrating meaningful use of EHR. Currently, Medicaid health plans are subject to numerous quality measurement requirements. Most state Medicaid programs utilize NCQA's HEDIS measures for measuring the quality of care provided through Medicaid health plans that serve over 21 million Medicaid beneficiaries.

- We recommend that the final rule require that providers report measures consistent with HEDIS measures, where possible, and that measures align with CMS quality reporting programs.
- We recommend that CMS reduce the number of required measures as part of simplifying the meaningful use criteria.

We appreciate your consideration of these comments. For more information, please contact me at TJohnson@mhpa.org or (202) 857-5725, or Alix Love, Medicaid Policy Manager, at ALove@mhpa.org or (202) 857-5720.

Sincerely,



Thomas L. Johnson
President and CEO