

Medicaid *Moving Forward*

*Improving Care & Transforming
Medicaid Delivery Systems*



Issue 2



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Executive Summary

The year 2013 was a busy one for both states and the Centers for Medicare & Medicaid Services (CMS). While focused on implementing new provisions of the Affordable Care Act, states have also been increasingly targeting their attention to delivery system and payment reform. Driven by the nation's governors working in their own states and in partnership with each other, new strategies are taking root across the country and states continue to pursue creative strategies to deliver better care at lower cost. CMS has encouraged and supported these efforts with new tools and strategies to improve quality of care and health outcomes for beneficiaries and to promote efficiency and cost effectiveness in Medicaid and the Children's Health Insurance Program (CHIP). This report highlights some of those activities, identifies the new tools and resources available to states, and summarizes new opportunities for states to build on their progress and successes.

Our work in 2013 began with a **letter** from Department of Health and Human Services (HHS) Secretary Sebelius to governors regarding existing and newly proposed flexibilities in the Medicaid program. This letter responded to states' suggestions for CMS to support state flexibility to design and administer Medicaid, and to reaffirm CMS' commitment to strengthening Medicaid. The Secretary's letter noted our strong interest in promoting both new and existing flexibility to improve coverage and care and to lower costs, and identified a variety of flexibilities available to states. Throughout 2013, states took advantage of many of these flexibilities. January's letter also promised changes to cost sharing rules for prescription drugs and emergency room use, and more ideas about delivery system design. Over the course of 2013, CMS delivered on these promises by issuing new guidance and by providing states with technical assistance through our State Operations and Technical Assistance (SOTA) teams, our Medicaid and CHIP **Learning Collaboratives** and other resources and tools.

Work in 2014 will build on – and substantially deepen and accelerate – this work. Early this year, the National Governors Association Health Care Sustainability Task Force carefully studied system transformation, focusing on state innovations that require the redesign of health care delivery and payment systems with the objectives of improving quality and controlling costs. The Task Force recommended various federal actions. In response to these recommendations, as well as to what we have learned through state activities over the course of 2013, CMS is excited to be strengthening the federal government's commitment to delivery system and payment reform in 2014 with the launch of a second round of State Innovation Models funding and a new project, the Medicaid Innovation Accelerator Program, aimed specifically at accelerating innovation in the Medicaid program.

The Medicaid Innovation Accelerator is a new collaboration from the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (the Innovation Center) working closely with the Medicare-Medicaid Coordination Office, the Center for Medicare, and other federal centers and agencies. The Innovation Accelerator Program is meant to jumpstart innovation in key areas while generally strengthening support to states as they take up the opportunity and tackle the challenges associated with service delivery and payment innovations in the Medicaid program. The Innovation Accelerator Program will be designed to assist states through strategically targeted activities aimed at advancing Medicaid delivery system and payment transformation. Through the Innovation Accelerator Program, we intend to build on past experience and respond to recommendations from our state partners for CMS to develop new guidance and resources and to offer technical assistance to accelerate Medicaid-focused innovations in order to improve health, improve health care, and decrease costs in this critical program. These resources will not only enhance the effectiveness of existing grant or funding opportunities in Medicaid, but will also enable greater alignment of innovations in Medicaid with those of other private and public payors. For more information, visit the **Innovation Accelerator Program** webpage.

These are exciting times of forward movement for the Medicaid program as access to coverage is broadened and as both states and CMS continue to deepen their investments in delivery system and payment reform in 2014.

Key Developments in 2013

- I. **Connecting People to Coverage** — Improvements in care and better management of health care costs begin with people having coverage and access to care, including preventive and primary care in appropriate settings that can help people stay healthy and avoid more costly care. Throughout 2013, CMS continued its focus on supporting states so they could be prepared for new ways to process applications and make eligibility determinations and to achieve enrollment improvements as provided under the Affordable Care Act. For example, CMS:
 - Supported states' investments in streamlined, modernized eligibility systems.
 - Provided guidance and technical assistance and a model application to coordinate eligibility and enrollment with the Marketplace.
 - Provided states with new tools to streamline enrollment of individuals eligible for Medicaid and CHIP, such as strategies to enroll people identified through the Supplemental Nutrition Assistance Program (SNAP).
 - Issued new cost sharing rules and worked with states to develop flexible coverage options, sometimes relying on section 1115 demonstrations, to provide states with ways to implement coverage expansions suited to state and beneficiary needs.
 - Enhanced outreach and enrollment efforts and developed new mechanisms to share information across states and with the public.

- II. **Improving Quality of Care Through Payment and Delivery Reforms** — Many states have long been working to achieve better health and improved care at lower cost. Over the last year, CMS deepened the investment in these initiatives and actively partnered with state and federal agencies to drive quality improvement through payment and delivery systems reforms. CMS:
 - Collaborated with innovator states ready to take on delivery and payment reforms.
 - Issued guidance on the design and implementation of shared savings payment methodologies that reward providers for improving health, increasing quality, and lowering program costs to encourage all states to engage in payment and delivery reforms.
 - Shared ideas and best practices with states to support their efforts to more effectively deliver effective care to Medicaid beneficiaries with intensive or specialized health care needs, such as those with serious mental illness or who are frequent users of emergency room services.
 - Partnered with states to develop new care models and improve the way Medicare-Medicaid enrollees receive services; some states are partnering with CMS' Medicare-Medicaid Coordination Office to implement demonstrations to test new models of service delivery and financing for Medicare-Medicaid ("dual eligible") enrollees.
 - Focused on the needs of our beneficiaries accessing long term services and supports by providing states with guidance, tools, and funding opportunities to improve the availability of home and community-based services.
 - Developed numerous tools to bolster states' quality measurement efforts throughout 2013 and worked across HHS to align and update quality metrics.
 - Issued the first national Medicaid drug survey of retail community pharmacy invoice prices in November 2013 to help promote transparency and better pricing of pharmacy products.

III. **Modernizing Business Processes** — Amidst major programmatic changes during the course of 2013, CMS also took steps to engage states in their efforts to improve the efficiency of state Medicaid and CHIP program operations and our business processes with states. CMS:

- Supported modernization of state business processes through streamlined state plan amendment submissions and demonstration requests and enhanced data reporting and analysis capabilities.
- Issued guidance and implemented new processes to promote enhanced accountability and oversight of federal-state spending.

Building on this activity, CMS looks forward to a year of accelerated improvement in the Medicaid program and is committing significant new resources to this effort.

As always, CMS continues to welcome and value new ideas and initiatives proposed by states, such as those included in the National Governors Association’s Health Care Sustainability Task Force Report. These state recommendations spurred the formation of the Innovation Accelerator Program and have led to new collaborations with the nation’s governors. CMS remains committed to partnering with states, health care providers, and consumers while providing leadership and support through guidance, technical assistance, and dissemination of new tools and rapid sharing of learning. Join the CMS [listserv](#) to stay informed.

Background

The Medicaid program provides health insurance coverage for more than 60 million Americans, and historically has played an especially critical role in providing coverage for low-income children, pregnant women, individuals with disabilities, and seniors. Its breadth of coverage ranges from pediatric and prenatal care to the provision of long term services and supports. Federal financial support and flexibilities in program rules, along with new tools and options made available through the Affordable Care Act, have given states the platform to adopt a broad range of improvements and innovations in their Medicaid programs. In addition, effective in January 2014, coverage rules have been simplified and aligned across insurance affordability programs, and millions more low-income uninsured Americans are gaining coverage.

Medicaid is jointly funded by states and the federal government, and administered by states consistent with federal guidelines. States and the federal government each have key roles as responsible stewards of the program. CMS is committed to working with states and other partners to advance state efforts that promote health, improve the quality of care, and lower health care costs. We conduct this work mindful of the importance of coordination and alignment with both the commercial market and with Medicare, as well as with an understanding of the unique features of Medicaid, including the state-federal relationship and the composition and health needs of Medicaid enrollees. Through our daily work with states, and in conjunction with the Innovation Center, the Medicare-Medicaid Coordination Office, the health insurance Marketplace, and agencies across HHS, the Center for Medicaid & CHIP Services is fostering health care transformation. We are also modernizing the administration of the program by moving from a paper-driven, process-intensive approach to more streamlined ways of doing business with states. These changes are reducing burden while enhancing shared accountability with data-driven performance indicators and more robust and timely data on program operations, expenditures, and quality.

The Center for Medicaid & CHIP Services prepared this report to highlight new initiatives launched in 2013 focused on making it easier for states to achieve these goals and provides specific examples of how states and CMS used these tools to advance Medicaid state initiatives.

The initiatives are organized into three areas:

- I. Connecting People to Coverage
- II. Improving Quality of Care Through Payment and Delivery Reforms
- III. Modernizing Business Processes

I. Connecting People to Coverage

Improvements in care and better management of health care costs begin with people having coverage and access to care, including preventive and primary care in appropriate settings that can help people stay healthy and avoid more costly care. Throughout the last year, CMS continued its focus on the enrollment gains expected to begin by the end of 2013 to ensure that states had the tools they needed to complete implementation of the Affordable Care Act's many improvements. CMS supported states' investments in streamlined, modernized eligibility systems and also provided guidance and technical assistance about how best to coordinate eligibility and enrollment with the Marketplace.

All the while, CMS remained focused on working with states to enroll individuals already eligible for Medicaid and CHIP. For example:

- **Modernizing Eligibility & Enrollment** — In the summer of 2013, CMS issued a **second final rule** to implement provisions of the Affordable Care Act related to eligibility and enrollment, benefits, and cost sharing in Medicaid, CHIP and the Health Insurance Marketplace. This final rule provided further guidance to assist states with implementing the Affordable Care Act's plan for achieving a streamlined system of affordable health coverage. It completed the new structure of Modified Adjusted Gross Income (MAGI)-based eligibility rules, provided additional flexibility regarding benefits and cost sharing for state Medicaid programs, and codified several enrollment provisions included in the Affordable Care Act and the Children's Health Insurance Program Reauthorization Act (CHIPRA). After the rule was released, CMS sponsored a series of educational webinars for states, and also provided ongoing one-on-one technical assistance through our SOTA initiative.
- **Enhanced Funding for Eligibility System Improvements** — CMS issued **clarifying guidance** to explain the availability of enhanced Medicaid matching funding for eligibility staffing and to support information technology investments related to the substantial changes required in eligibility determination systems as a result of the Affordable Care Act. To ensure program integrity, CMS has used an advanced planning document (APD) process to confirm with states the specific implementation details prior to the states claiming enhanced funding. CMS also regularly monitors enhanced claims from states.
- **Model Single, Streamlined Application** — The Affordable Care Act directed the development and provision to states of a model application form that beneficiaries may use to apply for coverage through all of the Insurance Affordability Programs, including the Marketplace, Medicaid, CHIP, and the Basic Health Program, as applicable. CMS published summaries of the proposed data elements

Monthly Reports Show Enrollment Increases

Since November 2013, CMS has published **monthly reports** on state Medicaid and CHIP data, representing state Medicaid and CHIP agency eligibility activity for each month of the open enrollment period for the Health Insurance Marketplace. The data were reported to CMS from state Medicaid and CHIP agencies as part of the Medicaid and CHIP **Performance Indicator process**, an unprecedented effort in partnership with states to publicly report Medicaid and CHIP application, eligibility determination, and enrollment information on a monthly basis.

The reports supplement data on Marketplace activity released by HHS. Beginning with the report released on April 4, 2014, the performance indicator reports include data on the number of people enrolled in Medicaid and CHIP. A **recent report** shows that, as of the end of April, more than 6 million additional individuals were enrolled in Medicaid or CHIP than before the Health Insurance Marketplace opened on October 1, 2013 (based on before and after data from 48 states).

for public comment and consulted extensively with states and stakeholders to ensure that both the on-line and paper versions of the streamlined application would adequately support eligibility determinations for all insurance affordability programs. Throughout the year, CMS provided states feedback through SOTA calls and targeted technical assistance sessions to ensure that states developed applications in accordance with the established standards. In addition, CMS shared a **model renewal form** with states to facilitate streamlined renewals going forward.

- **Targeted Enrollment Strategies** — On May 17, 2013, CMS issued a **letter to State Health Officials** to help states facilitate enrollment in Medicaid and CHIP in 2013 and 2014. The letter offered states five options aimed at reducing the administrative burden on states and beneficiaries during the transition to new coverage during the initial Marketplace open enrollment period, when states were most likely to experience an influx of large numbers of Medicaid and CHIP eligible individuals. These options, outlined below, are also part of our ongoing effort to simplify and streamline the enrollment and renewal process:

- Implementing the early adoption of MAGI-based rules;
- Extending the Medicaid and CHIP renewal period so that renewals that would otherwise occur during the first quarter of calendar year 2014 (January 1, 2014 – March 31, 2014) occur at a later date;
- Enrolling individuals into Medicaid based on information collected to establish Supplemental Nutrition Assistance Program (SNAP) eligibility;
- Enrolling parents into Medicaid based on information collected to establish their children’s income eligibility; and,
- Adopting 12-month continuous eligibility for parents and other adults.

In response to this guidance, **CMS approved** 36 state requests to implement extended renewal periods; 15 state requests to implement the early adoption of MAGI-based rules; 6 requests to enroll individuals into Medicaid based on SNAP eligibility; and 4 requests to enroll parents into Medicaid based on their children’s income eligibility.

Fast Tracking Medicaid Enrollment

Six states – Arkansas, California, Illinois, New Jersey, Oregon, and West Virginia – have adopted a powerful new tool for facilitating Medicaid enrollment during the transition to new coverage during the first Marketplace open enrollment period. The new strategy, known as “administrative transfers,” allows states to use information already on hand – such as SNAP income data or information about parents with children already enrolled in Medicaid – to enroll eligible individuals into Medicaid while states complete implementation of their new eligibility and enrollment systems. To implement the strategy, states can, for example, send letters to SNAP participants and/or parents of children in Medicaid encouraging them to enroll. To enroll, the person either returns a simple form or calls a toll-free number. The state then gathers additional information needed to determine eligibility, such as documentation of citizenship, which can usually be accomplished electronically. Since October 1, 2013, the five states that have implemented this strategy report that more than 550,000 individuals have been fast tracked into Medicaid. New Jersey also was approved to conduct administrative transfers and began implementation in June 2014. To read more about how targeted enrollment strategies have helped newly eligible consumers gain Medicaid coverage, see the **State Highlights** section of Medicaid.gov.

- **Flexible Coverage Options** — As states consider whether to adopt the Medicaid expansion, CMS has collaborated with them to find options that work for them. Whether through new or existing state plan flexibilities or through section 1115 demonstrations, throughout 2013, CMS demonstrated a willingness to work with states to find workable approaches to improving coverage.
 - **Cost Sharing** — The **final Medicaid regulations** described on **page 7** update and simplify policies around Medicaid premium and cost sharing designed to promote the most effective use of services and to assist states in identifying cost sharing flexibilities. Specifically, the final rule gives states flexibility in cost sharing for prescription drugs and for non-emergency use of the emergency department, and updates the maximum allowable cost sharing levels for individuals with income under 100 percent of poverty. The final rule also creates one streamlined set of rules for all Medicaid premiums and cost sharing, and clarifies that the limit on out of pocket costs applies to all beneficiaries to ensure that coverage remains affordable for the lowest income Americans.

Updated Medicaid Cost Sharing Rules

	Individuals with Family Income ≤100% FPL	Individuals with Family Income 101-150% FPL	Individuals with Family Income >150% FPL
Outpatient Services (physician visit, physical therapy, etc.)	\$4	10% of cost the agency pays	20% of cost the agency pays
Inpatient Stay	\$75	10% of total cost the agency pays for the entire stay	20% of total cost the agency pays for the entire stay
Drugs			
Preferred Drugs	\$4	\$4	\$4
Non-Preferred Drugs	\$8	\$8	20% of cost the agency pays
Non-emergency Use of the Emergency Department			
Non-emergency Use of the Emergency Department	\$8	\$8	Cannot Equal or Exceed the Amount the Agency Pays for the Service

- **Section 1115 Demonstrations** — In 2013, CMS approved 98 section 1115 **demonstration actions** implementing delivery system reforms, expanding benefits and services, and transitioning newly eligible populations into 2014 coverage. In the area of coverage improvements, while most of the states expanding Medicaid coverage effective in January 2014 relied on existing or new state plan authorities (that is, no waiver was required) CMS approved several new state models that authorized Medicaid expansions suited to fit the needs of individual states. These new initiatives include new frameworks to promote detailed, rigorous evaluations of these demonstrations. For example:
 - › **Premium Assistance Demonstrations (“Private Option”)** — In September 2013, CMS approved Arkansas’ Premium Assistance section 1115 demonstration, which the state refers to as the “Private Option,” as a vehicle for the expansion of Medicaid made

possible by the Affordable Care Act. This was the first application CMS approved for a state to use Medicaid premium assistance to provide eligible individuals Medicaid coverage delivered through Qualified Health Plans (QHP) offered in the Marketplace. Nonexempt beneficiaries enroll in coverage through the QHP and receive “wrap-around” coverage/cost sharing from the state Medicaid agency for those required benefits not covered by the QHP. CMS approved a similar proposal for Iowa.

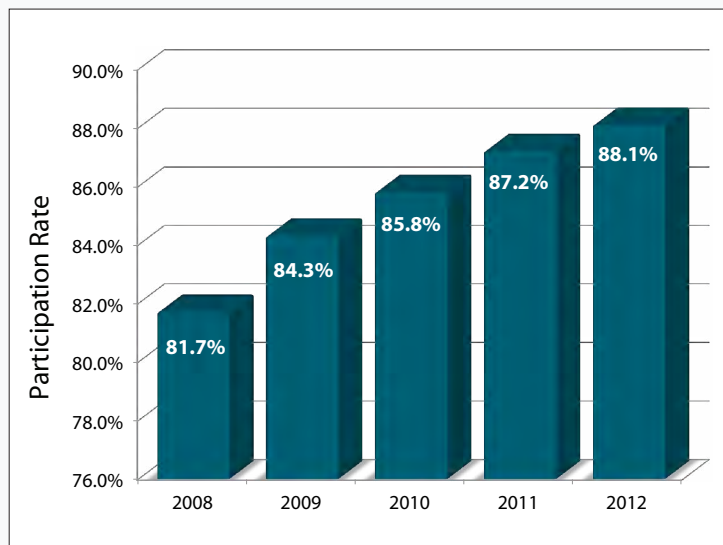
- › **Incentives for Healthy Behaviors** — CMS also approved section 1115 demonstration proposals from Iowa and Michigan to help promote healthy behaviors. Covered services will be furnished in ways that promote coordinated care, including the use of managed care and Accountable Care Organizations (ACOs) under the Medicaid state plan. The Iowa Health and Wellness Plan program is designed to promote healthy behaviors through education and engagement of beneficiaries and providers, and includes an incentive component that is intended to promote healthy behaviors. In Michigan, a new demonstration will establish a Healthy Behaviors program under which a beneficiary is eligible to reduce his/her premium payment amount by engaging in health improvement activities.
- **Hospital Presumptive Eligibility** — In 2013, CMS finalized regulations to implement the Affordable Care Act’s provision regarding hospital presumptive eligibility. For years, states have had the option to use presumptive eligibility to connect likely eligible pregnant women and children to Medicaid coverage. Hospitals were often key to implementing presumptive eligibility for those populations. Effective in January 2014, the Affordable Care Act gives qualified hospitals a unique new opportunity to connect additional populations to Medicaid coverage. Under the new presumptive eligibility authority, hospitals will be able to immediately enroll patients who are likely eligible under a state’s Medicaid eligibility guidelines for a temporary period of time. During 2013, states worked on developing their training materials and applications to use with hospitals interested in this option. To assist in this effort, CMS provided a **series of guidance and tools** for states implementing hospital presumptive eligibility, including proposed and final regulations, several all-state SOTA calls and webinars, state “affinity group” discussions, and a model set of training materials, application, and memorandum of understanding for states to use in educating hospitals about presumptive eligibility.
- **CHIPRA Performance Bonuses** — At the end of 2013, **CMS awarded** more than \$307 million in Fiscal Year 2013 Children’s Health Insurance Reauthorization Act (CHIPRA) Performance Bonuses to 23 states. The CHIPRA Performance Bonuses were created to give states an incentive to support the enrollment and retention of eligible children in Medicaid and CHIP and to help defray the costs associated with increasing enrollment of the lowest income children. Many of the simplification options that states adopted to qualify for a CHIPRA performance bonus – including joint Medicaid/CHIP application and renewal forms, elimination of in-person interview requirements, and a streamlined renewal process – are in place in all states in 2014 and applied consistently across Medicaid, CHIP, and the Health Insurance Marketplace. These simplifications have led to a less burdensome enrollment experience for families, improved coverage rates, and have helped lay the groundwork for enrollment efforts aimed at enrolling people now eligible for coverage under the Affordable Care Act.
- **Connecting Kids to Coverage** — The **Connecting Kids to Coverage Campaign** ramped up its nationwide efforts to provide outreach training and support to our grantees and partners who are working hard to help enroll all eligible children in Medicaid and CHIP. In 2013, our outreach efforts focused attention on enrolling eligible parents and their children since a large body of evidence shows that enrolling eligible parents helps get children covered and makes it more likely that children and parents will get preventive care. In 2014 there will be an even greater opportunity to get parents and other adults covered in states that expanded Medicaid coverage.

During 2013, the Campaign led waves of activity around cold and flu season, asthma and allergy season and back-to-school time, and produced engaging, customizable posters and flyers in several

languages. These materials were also transformed for use in outdoor advertising on billboards and public transportation in ten target media markets. The Campaign produced a television public service announcement broadcast on major networks, which also was made available to partner organizations to post on their websites, air in clinic waiting rooms and use in educational activities. These and other materials – including training webinars and a growing outreach video library – can be found on the [Insure Kids Now website](#).

In addition, CMS awarded 41 Connecting Kids to Coverage Outreach and Enrollment Grants to state and local governments, tribal organizations, community groups, schools, health care providers and others in 22 states, totaling nearly \$32 million. This round of grants is the third in a series, first funded under CHIPRA, and now supported with funding from the Affordable Care Act. Grants were targeted in the states with the largest numbers of children who are eligible for Medicaid and CHIP but are not enrolled. Connecting Kids to Coverage grants are funding efforts that take a variety of approaches to outreach and enrollment. Projects are focusing on school-based strategies and activities aimed at boosting enrollment of eligible Latino children, as well as efforts to build up the availability of application assistance in low-income communities. In addition, grants were awarded to organizations that are conducting training for community groups, providers and others on changes in Medicaid and CHIP eligibility and enrollment procedures so that communities can better respond to families and individuals who need help obtaining coverage.

Medicaid/CHIP Enrollment Among Children Continues to Improve



Source: Analysis of the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation based on American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) from 2012.

For more information on data and methods:

<http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf>

The dramatic decline in the rate of uninsurance among children – now less than 7% – is primarily a result of enrollment in Medicaid and CHIP. The latest state-by-state Medicaid/CHIP participation rates from the Urban Institute show that the nation continues to make steady progress in enrolling eligible children in Medicaid and CHIP. The Urban Institute analysis shows that the share of eligible individuals who have enrolled in coverage has increased from 81.7% in 2008 to 88.1% in 2012. Twenty states and the District of Columbia now have participation rates of 90% or higher. State-by-state Medicaid/CHIP participation rates are available on [InsureKidsNow.gov](#). Researchers attribute this success to a number of factors, most notably, the steps states have taken to simplify and streamline enrollment and renewal so that eligible children have better access to health coverage. Outreach activities aimed at signing up eligible children have also played an important role.

- **Basic Health Program** — In another effort to help states expand coverage and create a bridge between Medicaid and the Marketplace, on September 25, 2013 CMS issued a proposed rule establishing the standards for the Basic Health Program. The program provides states the option to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. The proposed rule set forth a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, state administration and federal oversight. This proposed rule was followed by a payment notice providing the proposed funding methodology and data sources necessary to determine federal payments for states electing to implement a Basic Health Program in 2015. After careful consideration of public comments, the final Basic Health Program **rule** and **payment notice** were published on March 12, 2014.

Learning Collaboratives: A Forum for CMS/State Ideas and Problem Solving

The **Learning Collaborative** initiative continues to provide a unique opportunity to engage states to obtain input on emerging policies, solve implementation challenges, and promote experimentation. In 2013, CMS established a new Basic Health Program Learning Collaborative, during which discussions with states helped to shape the development of key aspects of the proposed regulations. Also in 2013, CMS revamped the Data Analytics Learning Collaborative to focus attention on performance indicators, ensuring that CMS would be ready to report state progress on enrollment and other measures beginning in 2014. The work of the Early Innovators Learning Collaborative (LC), the Federally-Facilitated Marketplace LC, and the Coverage LC played a critical role throughout 2013 in preparing states for the first open enrollment period that began on October 1, 2013.

Launch of New Medicaid.gov Features — Medicaid Moving Forward in 2014

To coincide with the beginning of the Affordable Care Act open enrollment period in October 2013, CMS launched a **new section on Medicaid.gov** designed to describe how state Medicaid programs are moving forward into 2014. As the improvements to the Medicaid and CHIP programs brought about by the Affordable Care Act took full effect, the new page outlines a comprehensive picture of states' implementation efforts and new eligibility levels for Medicaid and CHIP coverage. The *Medicaid Moving Forward in 2014* section includes a set of national tables that describe key programmatic features related to eligibility and the enrollment process for health coverage in 2014. The tables provide:

- MAGI-based Medicaid and CHIP **eligibility levels** by state.
- The **Marketplace model** each state is using in 2014.
- A description of the **eligibility verification policies** states are adopting.
- A listing of the states that are employing new **targeted enrollment strategies** to smooth the path to Medicaid and CHIP coverage in 2014.



The section also includes links to state-specific landing pages, which include state documents relating to MAGI conversion, eligibility verification, eligibility and enrollment systems, implementation of the single, streamlined application, and links to approved Medicaid/CHIP eligibility and benefits state plan amendments.

Another area, entitled "**Eligibility Data**" provides links to the monthly eligibility and enrollment reports prepared through our **performance indicator process**. We have also added a Medicaid.gov page to feature **State Highlights** that focus on innovative and successful practices states have adopted to promote enrollment. We are also developing issue-specific policy feature pages that are intended as a resource for states and other stakeholders. For example, we recently added a page that compiles available tools and resources on **tobacco cessation**.

II. Improving Quality of Care Through Payment and Delivery Reforms

States and CMS share a strong interest in achieving better health and better care at lower cost. The addition of millions of new beneficiaries emphasizes this need, and achievement of coverage across the populations within states will also create new opportunities for alignment of care and broad delivery reforms. Some alignment has already occurred as states prepared throughout 2013 for an influx of new Medicaid beneficiaries; over the course of 2013, CMS issued both a proposed and **final rule for Alternative Benefit Plans**, the coverage vehicle for the new Medicaid expansion population, and provided technical assistance to states as they designed and CMS approved benefit packages for the expansion population.

More broadly, CMS has been collaborating with our state partners in four key areas for improving quality of care and reforming payment and delivery systems. First, CMS is collaborating with innovator states that are ready to take on delivery and payment reforms. Second, CMS is providing states with tools and guidance to tackle the specific needs of Medicaid beneficiaries. Third, CMS focused particularly on beneficiaries needing long term services and supports. Finally, CMS is working to measure and improve quality in every state across our nation, coordinating with efforts underway in Medicare and the private market.

Clearly, these challenges are all linked, and CMS is working to build on synergies across these areas and across CMS, HHS, and all of our partners.

1. Collaborations to Transform Delivery and Payment Systems

- **Shared Savings Methodologies** — A number of states embarked on new initiatives to reward Medicaid plans and providers for improved health outcomes, increased quality of care and lower program costs. CMS supports states in these efforts. In August 2013, as part of our Integrated Care Model series, CMS released a **State Medicaid Director’s letter** to describe expectations and technical considerations for shared savings payment methodologies, which can incentivize states, health plans, and providers to invest in delivery system reforms by enabling them to share in savings that reforms generate. While no one method is prescribed, the letter discusses the core elements that should be considered in any shared savings proposal and answers a series of programmatic and technical questions to aid states in developing methodologies that incentivize better care and pay on the basis of true program savings. Arkansas, Louisiana, and Minnesota have already received approval to implement these payment models and several other states have proposals under review.
- **Increased Payments to Primary Care Physicians** — To help promote access to primary care, the Affordable Care Act included a provision to temporarily increase reimbursement for primary care payments for certain primary care services to equal Medicare Part B payments. States receive 100 percent federal matching funds for the increase in payments. CMS posted Medicaid fee-for-service and managed care guidance in the form of eight sets of **questions and answers** on Medicaid.gov to assist states in implementing the Affordable Care Act provision requiring payment at the Medicare rate for certain primary care services. The guidance assists states in identifying eligible providers and services and necessary system changes. CMS also developed and distributed to states the Medicare-like rates (developed using the 2009 Medicare conversion factor and 2013 RVUs and GPCIs) required to be paid for services eligible for increased primary care payments.
- **Quality and Delivery System Reform** — CMS released a letter to State Health Officials titled “**Quality Considerations for Medicaid and CHIP Programs**.” This letter is the fourth in the Integrated Care Model series that provides states with guidance on designing and implementing care delivery and payment reforms that can achieve our shared goals of improving health, striving for quality care, and reducing costs within Medicaid and the CHIP. The letter provides a framework for quality improvement and measurement—developed in consultation with states—consistent with CMS’ and HHS’ approaches in areas including measuring, monitoring, and improving the quality of health care in value-based payment models.



Robust Data to Reveal How Programs Are Working

Advancing delivery reform requires timely, accurate and complete data to measure and track change. As described in an [August 2013 State Medicaid Director Letter](#), all states are expected to begin reporting data under the Transformed Medicaid Statistical Information System (T-MSIS) in the summer of 2014. T-MSIS represents a significant evolution in the timeliness, quality, and robustness of Medicaid transaction data for purposes of program operations and integrity. With T-MSIS, states, CMS and the public will have access to claims, eligibility, provider, managed care, and third-party liability data that can be used as an important new resource for Medicaid innovation. T-MSIS offers a new paradigm for Medicaid reform through a common understanding of what works, and will allow states and CMS to leverage and apply that information.

- **Health Homes** — Created by the Affordable Care Act, the health home state plan option provides an opportunity for states to create a comprehensive person-centered system of care coordination through the delivery of health home services to Medicaid eligible enrollees with chronic conditions, supported by a temporary increased federal match. The main goals for the health home are to improve health outcomes that will result in lower rates of emergency room use, reduce hospital admissions, readmissions, and health care costs, create less reliance on long term care facilities and improve experience of care for Medicaid individuals with chronic conditions. Health home providers deliver a comprehensive system of care by integrating and coordinating all primary, acute, behavioral health (including mental health and substance use), and long term services and supports for individuals with chronic conditions to treat the “whole-person.” The health home provider also is responsible for providing linkages to other services and social support. As described in more detail [below](#), in 2013, CMS issued a [State Medicaid Director Letter](#) that recommended eight Health Home Core Quality Measures which will be used to evaluate care across all state health home programs once health home regulations are promulgated in 2014.

Given the high costs and utilization of enrolled beneficiaries, health home programs have the potential to improve the efficiency of care delivered to this group through improved care coordination and care management services. According to state-reported data:

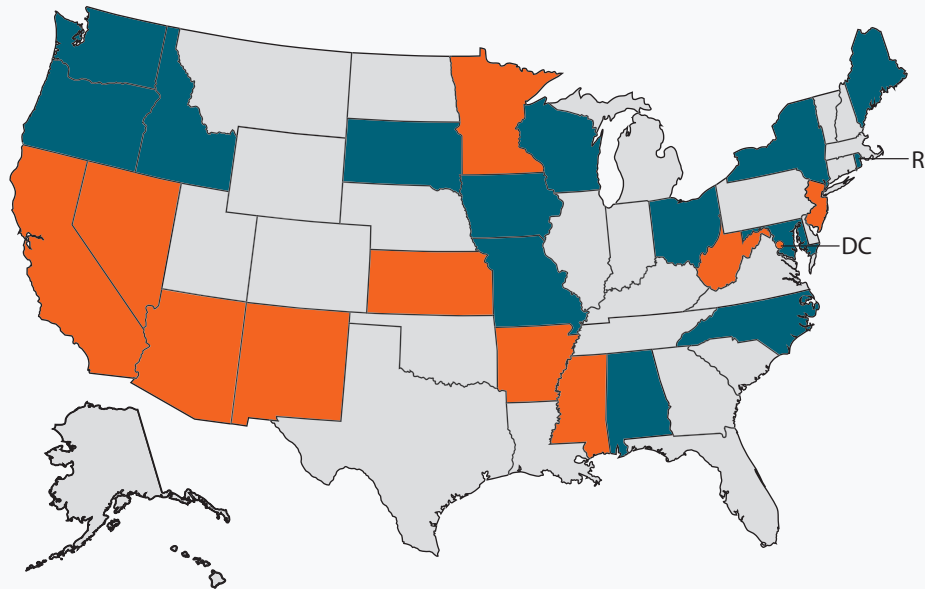
- Early data from Missouri’s Community Mental Health Center (CMHC) integrated health home show an annual reduction in hospital admissions and emergency room use. As a result, CMHC health homes save the state \$76.33 per member per month in total Medicaid costs and will be expanding enrollment by 25-30 percent in 2014.
- In New York, health homes are a critical element in the state’s Medicaid reform efforts. Early data shows that utilization and spending for inpatient services has decreased by approximately 30 percent for those who are continuously enrolled in health homes.



CMS continues to evaluate outcomes from states that have implemented health homes and will issue findings as they become available. Preliminary analysis suggests that participating states are seeing successes with patient empowerment, improved care coordination, integration of physical and behavioral health services, care transitions, and access to health care and other community-based services. This national initiative is an important step toward improving health care quality and clinical outcomes for high-cost, high-need patients and improving their experience of care, while also providing more cost-effective care.

A Growing Number of States Have Health Home Programs

As of December 31, 2013, 14 states have approved health home state plan amendments. Ten more states and the District of Columbia have been approved for planning grants.



- Approved Health Home State Plan Amendments: Alabama, Idaho, Iowa, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Washington, and Wisconsin
- Approved for Planning Grants: Arizona, Arkansas, California, District of Columbia, Kansas, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, and West Virginia

- **Improving Care for “Super-utilizers”** — One percent of Medicaid beneficiaries represent 25 percent of spending. In an attempt to lower costs through care improvement, CMS issued an **Informational Bulletin** to share details of care delivery and payment models to help states and Medicaid providers better meet the complex needs of “super-utilizers” — beneficiaries with complex, unaddressed health issues and a history of frequent encounters with health care providers who drive acute care utilization in the Medicaid program. For example, a North Carolina transitional care initiative that is designed to address the care of high need beneficiaries reduced hospital readmissions by 20 percent. CMS is committed to supporting innovative care delivery models that have the potential to improve care, improve health and, in so doing, reduce costs. The CMS Innovation Center has approved multiple Health Care Innovation Award grants for superutilizer programs, and the National Governors Association has a related state initiative.
- **Pharmacy Survey to Aid States in Efficiently Pricing Prescription Drugs** — In an effort to increase transparency in drug pricing and help states determine appropriate payments to pharmacies, CMS finalized a national Medicaid drug survey of retail community pharmacy invoice prices in November 2013. This voluntary monthly **survey** gathers invoice pricing information on covered outpatient drugs purchased by retail community pharmacies, including independent community pharmacies and chain pharmacies. The resulting pricing files, termed the **National Average Drug Acquisition Cost (NADAC)**, are posted on Medicaid.gov and are updated on a weekly basis. The NADAC files represent a national pricing benchmark that states can consider when setting their reimbursement methodology. States must submit a Medicaid state plan amendment to CMS if they decide to use NADAC when setting payment for drugs.

- **Delivery System Reform in 1115 Waivers** — While much can be accomplished without waiver authority, in recent years, some states have used section 1115 demonstration authority to engage in delivery system reform. These initiatives vary by state but in general CMS has worked with states to design focused transformation efforts that address specific issues and needs in those states while beginning to align such initiatives with broader Medicare and commercial market activities to encourage system-wide reforms. CMS continues to work with states to improve the measurement and evaluation of 1115 demonstration projects in order to support shared learning.

Oregon Coordinated Care Organizations One Year Later

In 2012, CMS approved a landmark section 1115 demonstration amendment for the state of Oregon, relying on Coordinated Care Organizations (CCOs) to deliver community-driven, coordinated care to Medicaid beneficiaries. The CCOs have begun operation and more than 614,000 beneficiaries were enrolled as of December 2013. Under the demonstration, Oregon is held to quality and spending metrics to ensure that quality continues to improve even as the state and the CCOs control costs. Working with CMS, Oregon has now finalized the process by which it will evaluate curriculum development and training practices used by non-traditional health workers. It has also begun learning collaboratives with CCO medical officers, quality improvement directors, CCO Community Advisory Committees, and Innovator Agents. In 2013 Oregon also finalized metrics that will be used for performance incentive payments. While it is too early for reporting of validated quality metrics, early data show an initial reduction in emergency department visits and an increase in primary care utilization.

- **State Innovation Models** — The CMS Innovation Center and the Center for Medicaid and CHIP Services have been collaborating closely on multiple projects to advance state-based reforms in their health care systems. The **State Innovation Models initiative** has been a principal focal point of these collaborations.

Medicaid and Innovation Center Collaboration

In addition to using Medicaid state plan amendments and section 1115 and 1915 waiver authorities to drive innovation and system transformation under Medicaid and CHIP, many states have either already been involved in, or plan to participate in, initiatives led by the CMS **Innovation Center**. A state's involvement with the Innovation Center might include a grant under the State Innovation Models, or indirectly, for example, under grants provided to providers and health departments in the state who are testing improvements in local service delivery and population-based health outcomes. In addition, section 3021 of the Affordable Care Act provides the Innovation Center with different but complementary authority to support innovation and transformation across all-payers; and Innovation Center models frequently include important elements of reform that focus on Medicaid.

Collaboration to Enhance Services for Medicare-Medicaid Beneficiaries

As of the end of 2013, ten states have entered into arrangements with the **Medicare-Medicaid Coordination Office** (MMCO) to leverage the Office's expertise and other resources aimed at improvements in service delivery to beneficiaries who are enrolled in both Medicare and Medicaid. MMCO was established under section 2602 of the Affordable Care Act, and its mission is to assure that Medicare-Medicaid enrollees have full access to seamless, high quality health care and to improve beneficiary experiences and outcomes. MMCO and Medicaid collaborate routinely, along with other Federal agencies, states and stakeholders to align and coordinate benefits between these two programs. Both MMCO and Medicaid partner with states to develop new care models and improve the way Medicare-Medicaid enrollees receive services; some states are partnering with CMS to implement demonstrations to test new models of service delivery and financing for Medicare-Medicaid enrollees. Additionally, MMCO and Medicaid also are coordinating on the alignment of a core set of measures and on measurement development efforts related to long term services and supports. Any state may leverage Medicare data and other technical assistance available through MMCO in its efforts with Medicaid to better coordinate care to this population across primary, acute and behavioral health and to better integrate long term services and supports.

2. Tackling the Specific Care Challenges

- CMS issued a series of Informational Bulletins to share information and tools to help states improve care for high need populations. For example:
 - **Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions** — With the Substance Abuse and Mental Health Services Administration (SAMHSA), CMS issued an **informational bulletin** to assist states to design a benefit that will meet the needs of children, youth, and young adults with significant mental health conditions.
 - **Integrated Trauma Care** — CMS, along with federal partners at the Administration of Children and Families (ACF) and SAMHSA, released a **joint letter** intended to encourage the integrated use of trauma focused screening, functional assessments and evidence-based practices in child-serving settings for the purpose of improving child well-being. CMS, ACF and SAMHSA are engaged in an ongoing partnership to address complex, interpersonal trauma and improve social-emotional health among children known to the child welfare systems.
 - **Improving Oral Health** — CMS also released an **informational bulletin** providing updates related to the CMS Oral Health Initiative. The bulletin announced completed CMS baselines and goals for children's use of preventive dental services nationally and in each state Medicaid program. The bulletin also encouraged states to submit oral health action plans as a road map to achieving their goals and informed states that technical assistance from the CMS dental team is available. Finally, CMS used the bulletin to inform states that two new dental codes for diagnostic services are available to support states' efforts to improve access to dental services. These codes do not specify a dentist as the rendering provider and should maximize the ability of all healthcare professionals, operating within the scope of state practice acts, to serve Medicaid and CHIP enrollees.



- **Reducing Emergency Department Utilization** — Continuing on the series of informational bulletins released in 2013, in January of 2014, CMS released an **informational bulletin** that provides strategies that states can use to reduce non-urgent use of emergency departments and improve appropriate care in appropriate settings. The strategies suggested for reducing non-urgent use of emergency departments are broadening access to primary care through health homes and alternative primary care sites, focusing on frequent emergency department users (also known as “super-utilizers”), and targeting the needs of people with behavioral health problems. The bulletin provides examples of communities that have successfully implemented each strategy. The bulletin recognizes that states may struggle with interpreting federal statutes that allow them to develop payment methodologies that encourage providers to direct patients to more appropriate care settings and provides guidance on interpreting the relevant laws.

- **Prevention Activity**

- **Increased Federal Payment for Preventive Services** — On February 1, 2013, CMS released a **State Medicaid Director Letter** to provide guidance to states on section 4106 of the Affordable Care Act. The law establishes a one percentage point increase in the federal medical assistance percentage (FMAP) effective January 1, 2013, applied to expenditures for specified preventive services assigned a grade of A or B by the United States Preventive Services Task Force, and approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices. States that cover in their standard Medicaid benefit package all the recommended preventive services and adult vaccines, and their administration, without cost sharing on such services, can receive the added federal financial support.

Washington State Demonstrates Ways to Reduce Emergency Department Use

Washington state implemented seven best practices for reducing emergency room usage, including best practices identified in the CMS informational bulletin on this topic, such as enhanced systems to exchange information, targeted efforts to address prescription drug abuse, and enhanced efforts to help patients navigate to primary care. As a result, during fiscal year 2013, the state reports that the rate of emergency department visits declined by 9.9 percent, and the rate of low acuity visits decreased by 14.2 percent. Although it cannot be attributed fully to this effort (the state also transitioned some beneficiaries into managed care), estimated annual savings for the Medicaid program in Washington state was over \$30 million.

- **Oral Health** — To bring attention to oral health and its impact on overall health, as well as to highlight the dental benefits children get when they enroll in Medicaid or CHIP, the CMS Connecting Kids to Coverage Campaign created a special **Oral Health page** on the Insure Kids Now website. The page features a set of newly developed oral health education materials under the theme “THINK TEETH.” The materials not only make the connection between enrollment and dental coverage, they also explain the simple steps pregnant women and parents can take to keep their own mouths and their children’s mouths healthy. The free materials are available in both English and Spanish and can be bulk ordered from CMS through the Insure Kids Now website. CMS has promoted the materials through provider organizations, state Medicaid and CHIP agencies, community-based organizations and others.

CMS also developed an oral health strategy guide, **Keep Kids Smiling: Promoting Oral Health through the Medicaid Benefit for Children & Adolescents**. The strategy guide, developed for states, aims to improve child oral health services delivered through Medicaid and CHIP. The guide provides an overview of the children's dental benefit in Medicaid, support for evidence-based policies at the state level, and details of successful strategies with state examples. CMS has shared the guide through the CMS Learning Lab, Oral Health Technical Advisory Group, oral health conferences, technical assistance webinars, and websites.

- **Improving Infant and Maternal Health** — CMS, in collaboration with state partners, has worked on various fronts to improve infant and maternal health. For example, CMS is working with the Medicaid Medical Directors to support their quality improvement projects focused on reducing early elective deliveries. In collaboration with CMS and the Centers for Disease Control and Prevention, the Medicaid Medical Directors have developed an **initiative** to enhance state data capacity using matched vital records and Medicaid eligibility/claims data. Other targeted efforts also have supported this work:
 - › **Strong Start Initiative** — CMS launched the **Strong Start for Mothers and Newborns Initiative** in 2012. Led by the Innovation Center, the initiative includes two primary strategies: (1) testing ways to encourage best practices for reducing the number of early elective deliveries that lack medical indication across all payer types; and (2) a grant program to test and evaluate three models of enhanced prenatal care for reducing preterm births, decreasing the cost of medical care during pregnancy, delivery and over the first year of life among Medicaid or CHIP beneficiaries. In February 2013, 27 grants were awarded for up to \$41 million to support the testing of enhanced prenatal care through three approaches: group or centering visits, at birth centers, and at maternity care homes.
 - › **Text4baby State Launch** — CMS hosted a kick-off for a three year pilot project with **Text4baby** to work in collaboration with four states (California, Louisiana, Ohio, and Oklahoma) to customize mobile messages to provide expecting and new mothers with targeted information to improve performance on CMS core quality measures. Text4baby is a mobile information service designed to promote maternal and child health through text messaging. Participants receive three free educational text messages a week, timed to their due date or their baby's birth date, through pregnancy and up until the baby's first birthday. The messages address topics such as labor signs and symptoms, prenatal care, developmental milestones, immunizations, nutrition, birth defect prevention and safe sleep.
 - › **Building Bridges between Public Health and Medicaid** — CMS is partnering with the Health Resources and Services Administration (HRSA) in its Collaborative Improvement and Innovation Network (**CoIIN**) to improve access to postpartum visits and inter-conception care for women covered by Medicaid who had an adverse pregnancy outcome.
- **Expanding Coverage for Certain Prescribed Drugs to Promote Smoking Cessation** — CMS provided guidance to states on a new statutory requirement to **cover certain prescribed drugs** related to smoking cessation in September 2013. Effective January 1, 2014, states were required to cover certain prescription and over the counter drugs used to promote **smoking cessation** for Medicaid beneficiaries. For Medicaid beneficiaries also enrolled in Medicare, their Part D plan already provides coverage of these prescription drugs categories; however, Part D does not generally cover over the counter drugs. States are now responsible for coverage of over the counter smoking cessation drugs for all Medicaid beneficiaries, including Medicare-Medicaid eligible beneficiaries.

3. Improvements in Long Term Services & Supports

- **Managed Long Term Services and Supports** — As states have expressed increasing interest in delivering long term services and supports through managed care, over the course of 2013, CMS released **several documents** to promote quality and effective Medicaid managed long term services and supports (MLTSS) initiatives. The guidance was developed based on review of successful state experience and input from states, consumers, and HHS partners. The documents released include: a high level overview; guidance on CMS expectations for operating an MLTSS program under a section 1115 demonstration or 1915(b) authority combined with another LTSS authority; a suggested timeline for implementation of an MLTSS program; a paper discussing the challenges and suggested approaches to transitioning existing LTSS providers into a managed care system; and an information bulletin announcing the availability of another new resource on Medicaid MLTSS to support states and other partners in enhancing the quality of these services. States can rely on these materials as they design their initiatives, and CMS will use them to review state MLTSS program proposals and contracts in order to ensure programs have a strong basis for success during implementation and for the life of the program. CMS also posted a road map for states to use in interpreting and applying existing External Quality Review protocols when assessing MLTSS program compliance.
- **Encouraging Care in the Community** — A major priority for CMS is to increase opportunities for individuals to receive the long term services and supports they need in their homes and their communities. Over the course of 2013, CMS continued to encourage and support states in their efforts to deliver care to Medicaid beneficiaries in the most appropriate, **community-integrated settings**. CMS supported states through a variety of options and initiatives:
 - **State Plan Home and Community-Based Services Benefit** — Under this state plan option, qualifying individuals can receive long term services and supports (such as extended state plan services, respite, case management, supported employment, and environmental modifications). As of 2013, CMS had approved 16 state plan HCBS benefits in 14 states: California, Colorado, Connecticut, Florida, Idaho (2), Indiana (2), Iowa, Louisiana, Michigan, Mississippi, Montana, Nevada, Oregon, and Wisconsin.
 - **Balancing Incentive Program** — Over the course of 2013, CMS approved 9 more states for participation in the Balancing Incentive Program to increase access to non-institutional long term services and supports. As of the end of 2013, the total number of states participating in the program was 17, with a total projected award amount of over \$2.1 billion. Participating states as of the end of 2013 include: Arkansas, Connecticut, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Mississippi, Missouri, New Hampshire, New Jersey, New York, Ohio and Texas.
 - **Community First Choice Option** — Community First Choice gives states the option to provide home and community-based attendant services to Medicaid enrollees with disabilities under the Medicaid state plan. CMS approved Oregon’s request to implement the Community First Choice Option, making them the second state behind California to take up this Affordable Care Act option.
 - **Preadmission Screening and Resident Review Programs** — CMS released its **Second National Report on State Preadmission Screening and Resident Review** programs, which revealed that states achieved over 50 percent improvement in comprehensiveness of their program design, compared to the first report on 2009 data. Improved programs mean individuals with mental illness or intellectual disability are more effectively evaluated, more likely to receive services that better meet their disability-specific needs, and in the most appropriate community-integrated setting. Over the course of the year, CMS provided states with no-cost training and technical assistance through our Technical Assistance Center — all states participated in a webinar series and 18 states received formal individualized assistance with person-centered evaluation and service planning, rebalancing, obtaining 75 percent matching rate, IT systems, and related topics.

- **Direct Service Workforce Initiative** — Building on **existing resources**, CMS released two publications to assist states in recruiting and retaining direct service workers:
 - › **Road Map of Core Competencies for the Direct Service Workforce: Phase III – Core Competency Synthesis and Validation;**
 - › **Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting: A Toolkit for State Medicaid Agencies.**

New York and Iowa are implementing these core competencies for selected direct service workers in their respective states, and Ohio is using the toolkit to implement Medicaid rate setting for select populations.

- **Money Follows the Person** — Rebalancing efforts under **Money Follows the Person** continue to expand as transitions increased to over 31,000 participants moving from institutional settings into the community in the **first part of 2013**. These transitions have generated over \$90 million in rebalancing fund expenditures on transitioning services, expanded waiver services, data systems improvements, outreach, staff training, assessment tool development, and research. Forty-four states and the District of Columbia currently participate in the demonstration.
- **Community Alternatives to Psychiatric Residential Treatment Facilities** — In July 2013 the **final report to Congress** was released for the Psychiatric Residential Treatment Facilities demonstration. Significant findings of the report include: services in the community were at least as effective, and in the case of children with the most significant level of need, more effective than institutionally based services. Additionally, the cost of providing the community-based services alternative was only 32 percent of the cost of providing services within an institutional setting.
- **Housing** — CMS continues to collaborate with the Department of Housing and Urban Development (HUD) to increase access to and availability of affordable, integrated housing for persons with disabilities and chronic conditions. CMS and HUD senior policy advisors meet weekly to collaborate and work with our regional staff, supporting regional team building and coordination between HUD and CMS staff. And since 2011, HUD and CMS staff and leadership have convened a one day meeting each year to coordinate and communicate our work together, on policy, regulations, and Olmstead guidance to states and other jurisdictions. One recent example of our collaboration is HUD's 811 Project Rental Assistance program, authorized by the Frank Melville Supportive Housing Investment Act of 2010. CMS works closely with HUD staff, and provides input on the **HUD Notices of Funding Availability**, participates in applicant evaluations and supports applicants and grantees through technical assistance. Rental assistance funds are awarded primarily to state housing agencies that form partnerships with state Medicaid and health and human services agencies that have developed methods for identifying, referring, and conducting outreach to extremely low-income persons with disabilities who require long term services and supports, many of whom are transitioning out of institutional settings or are at high risk of homelessness.



- **Money Follows the Person Tribal Initiative** — In 2013, CMS released the **Money Follows the Person Tribal Initiative funding opportunity announcement** and awarded grants in early 2014. The program offers existing Money Follows the Person grantees and tribal partners the resources to build sustainable community-based long term services and supports specifically for Indian country. The Tribal Initiative may be used to advance the development of an infrastructure required to implement community-based long term services and supports for American Indians and Alaska Natives. Funding is intended to support the planning and development of in-state Medicaid program community-based services (as an alternative to institutional care) tailored for American Indian and Alaska Natives who are presently receiving services in an institution and a service delivery structure that includes a set of administrative functions delegated by the state Medicaid agency to Tribes or Tribal organizations, such as enabling tribe(s) to design an effective program or package of Medicaid community-based services, and operating day to day functions pertaining to the long term services and support programs.

New Regulations Guide Transition to Community-Based Care

At the beginning of 2014, CMS published a **final rule on Home and Community-Based Services** to establish final requirements for home and community-based settings in Medicaid Home and Community-Based Services programs operated under sections 1915(c), 1915(i), and 1915(k) of the Social Security Act. The rule defines home and community-based settings by the quality of the individual's experiences and will effectuate the law's intention that Medicaid HCBS programs serve as a true alternative to institutional care. The final rule includes a process and timeframe for states to come into compliance with the settings requirements.

In addition to the settings requirements, the final rule also provides implementing regulations for the section 1915(i) HCBS State Plan option, including new flexibilities enacted under the Affordable Care Act that offer states the option to provide expanded home and community-based services and to target services to specific populations. The final rule also amends the regulations for the 1915(c) HCBS waiver program to add new person-centered planning requirements (across 1915(c) and 1915(i) programs), provide states with the option to combine multiple target populations into one waiver to facilitate streamlined administration, clarifies the timing of amendments and public input requirements for proposed modifications of HCBS waiver programs and service rates, and provides CMS with additional compliance options.

4. Improving Quality of Care

CMS is working with state and federal partners across the Administration to promote uniform reporting of quality measures across the entire Medicaid program and to align these measures with ones used by other payers. As we approach the start of operational reporting in the T-MSIS format (described in greater detail [below](#)), we will begin to open the door to a new depth of understanding regarding quality of care in the Medicaid program. We are also engaged in promoting quality across states' managed care programs, which is a key delivery system mechanism employed by states throughout the nation. Here are some key efforts over the past year to promote quality improvement across the Medicaid program:

- **Promoting Updated and Aligned Core Quality Measures** — During 2013, CMS continued work to update and align our Medicaid/CHIP core set of children's and adults' health quality measures. CMS issued both new and updated core sets of quality measures to promote standardized measurement of outcomes across the country, enabling states and the federal government to compare data within and among states. Activities include:
 - **Ongoing Processes to Align and Update Medicaid Quality Metrics** — The Medicaid and CHIP core measure sets undergo multiple processes at the agency level, the departmental level, and with experts and stakeholders, all to ensure alignment and parsimony to ease state reporting and increase the usefulness of measures across HHS programs. CMS and other parts of HHS are beginning to work together to maximally align measures across all HHS programs, including with an eye toward alignment with the commercial market. In addition, the Medicaid and CHIP adult and child core sets both undergo multi-stakeholder processes to allow for broad discussion and input by experts and external stakeholders, including state partners, to identify and update the core measure sets.
 - **Child and Adult Medicaid Core Set 2014 Updates** — At the end of 2013, CMS released an [informational bulletin](#) describing the 2014 updates to the Medicaid/CHIP Core Set of children's and adults' health quality measures. Updates to the adult set were based on input from the Medicaid Adult Task Force at the Measures Application Partnership, the multi-stakeholder process used to update this core set of health care quality measures. For the 2014 Child Core Set update, CMS partnered with the Agency for Healthcare Quality and Research (AHRQ) to conduct a multi-stakeholder process to identify which measures to retire from the Child Core Set. AHRQ's multi-stakeholder group included state Medicaid/CHIP representatives, health care policy officials, measure developers, and other children's health care experts.
 - **Health Home Core Set of Quality Measures** — CMS released a [State Medicaid Director's letter](#) recommending a core set of health care quality measures for assessing quality across all state health home service delivery models. While CMS is not requiring reporting these measures until the health home rules are issued, we shared the measures early to help states as they consider the design and implementation of their health home programs.
 - **Additional Progress in Reporting** — In 2013, the [Secretary reported to Congress](#) that all states and the District of Columbia had data for 2 or more Child Core Set measures, with a median of 14 measures for which data were being collected.

Quality Improvement Learning Series

Last summer, CMS launched a Quality Improvement Learning Series (QI 201), building on the successful Quality Improvement 101 webinar series attended by nearly 500 people. The QI 201 Series is a ten month learning series that involves 10 teams focused on developing and implementing specific maternal and infant health projects tailored to their own state needs.

- **Quality Improvement Grants to States** — To assist states in collecting and reporting the Medicaid Adult Core Set, CMS launched the Medicaid Adult Quality Measurement Program in December 2012. With funds from the Affordable Care Act, 25 states are participating in the two-year **Adult Medicaid Quality Grant Program**. Each state received up to \$1 million per year for the two-year project period. The three main goals are to:
 - Test and evaluate methods for collecting and reporting the Medicaid adult core set of quality measures in varying care delivery settings and payment arrangements;
 - Develop staff capacity to report the data, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid;
 - Conduct at least two Medicaid quality improvement projects related to the core set measures; states are encouraged to consider alignment with other federal quality improvement activities (such as Strong Start, Million Hearts, and the Partnership for Patients).
- **The CHIPRA Quality Demonstration Grants** are supporting two states (Florida and Illinois) in working to reduce early elective deliveries to improve maternal and infant outcomes.
- **Medicaid Managed Care Improvement** — CMS continues to undertake efforts to provide comprehensive information and guidance on Medicaid managed care program operations. Last year, CMS also announced the new **Medicaid Managed Care Technical Assistance Center** on Medicaid.gov. In collaboration with Mathematica Policy Research, Centers for Health Care Strategies, Manatt Health Solutions, and the National Committee for Quality Assurance (NCQA), CMS is providing individualized technical assistance to states on managed care program operations, including planning and procurement, benefit design and serving the needs of complex populations, access and quality, and the use of data for program oversight and management. In addition, to strengthen state capacity in program integrity oversight of Medicaid managed care, CMS provided training at the Medicaid Integrity Institute for 140 state employees from 38 states in two courses focused on managed care program integrity issues during FY 2013, at no cost to the states.

Grants Focus on Boosting Quality of Care

Twenty five states were awarded **Adult Medicaid Quality Improvement Grants** in December 2012. The grantee states are: Alabama, Arkansas, California, Colorado, Connecticut, Georgia, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. Of these, 10 states are implementing quality improvement projects related to maternal and infant health; of these, 5 states are implementing projects to reduce early elective deliveries, and 5 states are working to improve other measures of maternal health.

III. Modernizing Business Processes

CMS is also working to modernize business processes and making investments in state and federal systems, recognizing that better business processes will help sustain the enrollment gains and delivery system reforms taking place across the country. For example:

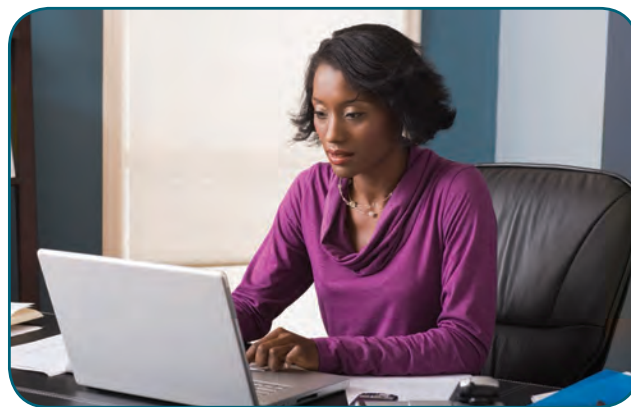
- **Streamlining State Plan Submissions** — CMS provided states with fillable PDF State Plan Amendment preprints in order to prepare for migration to an electronic state plan submission and approval system, known as MACPro. This improvement helped to streamline the submission of state plans, and to facilitate the move to the new system, CMS conducted training sessions for states on the process for completing and submitting the fillable PDFs. In 2014, CMS will launch the new MACPro technology to replace in a systematic manner our largely paper-based processes for states to request approval for design and operations decisions. This will support more effective and efficient responses to state requests, and provide CMS with better data about program operations.
- **Simplified Processes to Support States' Transition to MAGI** — To take advantage of the flexibilities to promote enrollment of eligible individuals through the targeted enrollment strategies described on [page 8](#), states must obtain a waiver under section 1902(e)(14)(A) of the Social Security Act. CMS established a simplified process for states to request and receive the necessary waiver authority. This simplified process also has been applied to assist states in transitioning to MAGI in other ways, including to transition individuals from coverage under a section 1115 demonstration to the new adult eligibility group created by the Affordable Care Act and to align verification procedures with the Marketplace. Under the simplified process, states send a letter to CMS. After reviewing the state's request with the state, CMS sends the state an award letter, providing the authorities needed as well as setting forth the terms and conditions for implementation. To complete the streamlined process, the state sends a letter back to CMS indicating that it accepts the authorities granted and agrees to the terms and conditions.
- **Transformed Medicaid Statistical Information System (T-MSIS)** — As described [above](#), T-MSIS represents a significant evolution in the timeliness, quality, and robustness of Medicaid transaction data for purposes of program operations and integrity, facilitating monthly reporting of encounter data and quality standards. Over the course of 2013, CMS provided technical assistance to states to help prepare for T-MSIS implementation. CMS released a [State Medicaid Director letter](#) officially announcing the implementation of T-MSIS with states on a rolling basis, with the goal of having all states submitting data monthly in the summer of 2014. The State Medicaid Director letter was followed by several webinars with all states and CMS also created a suite of tools to assist states in preparing to submit T-MSIS data. CMS is implementing automated tools to check, review, and provide near real-time feedback to states on their T-MSIS submissions, as well as developing a basic data analytic capability. Though states will transition to T-MSIS at different points in time, all states are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data.

This improved data submission is an integral part of state and CMS efforts to modernize the Medicaid and CHIP programs, and CMS is working with states to integrate T-MSIS into MMIS Advance Planning Document (APD) reviews (including enhanced funding requests for operation and maintenance for Medicaid Eligibility systems (75/25), Innovation Center grants, state demonstrations and section 1115 waiver demonstrations).

- **Performance Indicators** — Over the course of 2013 and in consultation with states, CMS developed a series of Performance Indicators for Medicaid and CHIP business functions, which CMS began collecting in association with increased funding available to states for the development of new IT systems. The goal is to have a common set of indicators, with standardized data across all state Medicaid and CHIP programs, to provide information to support program management and policy-

making at both the federal and state level. For the first time ever CMS will be able to make public on a near real-time basis standardized data across all state Medicaid and CHIP programs. The data will allow states to compare themselves to their peers, and stakeholders to analyze larger trends within the program. After finalizing 12 performance indicators in the area of eligibility and enrollment last summer, CMS began collecting and **publicly reporting** on select state data indicators in the fall, and plans to expand reporting to additional indicators in 2015. CMS intends to generate a baseline, and in subsequent years CMS, states, and stakeholders will work together to develop benchmarks and targets for performance improvement, and to expand the areas of focus.

- **Additional Accountability for Medicaid Expenditures**—In March 2013, CMS issued a **State Medicaid Director’s Letter** that discusses the mutual obligations of the state and federal governments to implement safeguards and ensure proper and appropriate use of Medicaid dollars. As an initial approach, the letter describes new efforts to analyze program and expenditure data, which will be aided by the T-MSIS, and a requirement that states submit annual upper payment limit (UPL) demonstrations for certain Medicaid services. In the past, states only submitted UPL demonstrations when requesting to change or update service payment methodologies in the Medicaid state plan. Beginning in 2013, states submitted the annual demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. In 2014 and annually thereafter, states will submit annual UPL demonstrations for the services listed above as well as clinics, physician services (for states that make supplemental payments targeted to physicians), intermediate care facilities for the developmentally disabled, psychiatric residential treatment facilities and institutions for mental disease. To aid states in developing their demonstrations, CMS posted **UPL guidance materials** on the Medicaid.gov website.
- **Predictive Analytics Technologies**—CMS operates a Fraud Prevention System to implement predictive analytics technologies to identify and prevent the payment of improper claims in the Medicare fee-for-service program. CMS is congressionally mandated to analyze the feasibility and cost-effectiveness of expanding the use of predictive analytics technologies to Medicaid and CHIP and, based on this analysis, CMS is required to determine whether to expand predictive analytics to Medicaid and CHIP by April 1, 2015. CMS is also analyzing the effect, if any, the application of predictive analytics technologies to claims under Medicaid and CHIP would have on states, commonwealths and territories. Although Medicaid is administered and organized in a distinctly different way than Medicare, a recent **Report to Congress** indicates that CMS anticipates that there are opportunities to transfer the knowledge and lessons learned about Medicare through the Fraud Prevention System to states for uses applicable to Medicaid. Several state Medicaid programs are already in the process of implementing predictive analytics technology as part of their program integrity efforts. CMS may approve enhanced Federal Financial Participation for predictive analytics technologies that are integrated with state Medicaid Management Information Systems (MMIS). As of the end of 2013, CMS had approved enhanced funding for five states to implement predictive analytics. As part of the evaluation of expanding predictive analytics to Medicaid, CMS is engaging in several activities, including providing technical assistance to states regarding factors to consider in implementing predictive analytics capabilities through the review of state-submitted Advance Planning Documents related to the procurement of predictive analytics technologies.




Conclusion

Building on activity and progress to date, CMS anticipates that 2014 will bring more progress as states and CMS continue to collaborate to move Medicaid forward. Among the key tools and resources that CMS has planned for 2014 are:

- CMS plans to issue **new Medicaid managed care rules** to modernize longstanding regulations and bring Medicaid managed care regulations into alignment with Marketplace standards, as applicable.
- **MACPro** and **T-MSIS** will go live, easing business operations for states and giving both CMS and states the ability for real time data analytics to help shape policymaking and further drive delivery system reforms.
- **Round Two of the State Innovation Models** initiative. The State Innovation Models initiative will provide financial and technical support to states to design or test innovative payment and delivery models that will improve health, improve care and lower cost for Medicare, Medicaid, and CHIP beneficiaries. CMS launched a second round of funding for the State Innovation Models initiative to support states to accelerate health transformation. This funding opportunity announcement expands on lessons learned from Round One by focusing on parameters CMS believes correlate with successful state health delivery and payment system transformation.
- In response to recommendations from the National Governors Association and mindful of feedback we have received from states across the country, CMS is launching a new collaborative initiative with the Innovation Center called the **Medicaid Innovation Accelerator Program**, which will help states accelerate their development and testing of new payment and service delivery models to improve health, improve care, and, through these improvements, reduce costs for the Medicaid program and the health system more generally. The Innovation Accelerator Program will provide infrastructure and resources needed to develop tools to address common challenges, for example in data analytics, quality and other performance measurement, and rapid cycle evaluation. The Innovation Accelerator Program will also work directly with states in their application of these tools and in supporting robust learning diffusion in identified program priority areas. Through the Innovation Accelerator Program, CMS will also focus on integrating, leveraging, and coordinating across CMS components' technical assistance efforts to better manage, process, and monitor new innovation work in Medicaid. In addition to general support for states, the Innovation Accelerator Program also will enable CMS to deepen its support for State Innovation Models states. The technical assistance and support to State Innovation Models states will be coordinated to leverage resources and experience that can help all states continue moving forward.



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