



MEDICAID MOVING FORWARD

*Opportunities for Achieving Improvements
in Care and Program Efficiency*



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Opportunities for Achieving Improvements in Care and Program Efficiency

EXECUTIVE SUMMARY

Throughout the nation—in the private and public sectors—attention is focused on new ways to improve health care and lower costs. This report highlights federal initiatives launched in 2012 to respond to, support, and encourage state efforts to achieve the goals in Medicaid and the Children’s Health Insurance Program (CHIP). It also shares specific examples of how states are using new tools and additional federal resources to advance their state initiatives. The report shows a Medicaid program focused on streamlining operations and supporting innovation and flexibility aimed at ensuring beneficiaries have access to high quality services delivered through effective and efficient systems of care.

To inform states and others of key changes, this Executive Summary identifies recent developments, opportunities available to states today, and upcoming activity. Each area is described more fully in the report, with links to Medicaid.gov for additional information and resources. As states and the federal government continue to innovate, we plan to publish future reports on new opportunities and progress.

KEY DEVELOPMENTS IN 2012

Over the past year there have been many important changes to the Medicaid program, including guidance regarding various provisions of the Affordable Care Act. CMS has:

- Issued guidance on a new state option for implementing integrated care models without a waiver that help states coordinate care in a fee for service delivery system;
- Issued rules on increased payment rates for Medicaid primary care providers, financed by the federal government, along with tools to aid states in the implementation of the rate increase;
- Launched a new website to help states better implement long term services and supports delivered in a capitated managed care system;



- Helped states and consumers to design new person-centered care programs and demonstrations and enhance current programs to improve coordination of care for Medicare-Medicaid enrollees;
- Released major new funding opportunities for states and health providers and plans to design and test new delivery system models focused on multi-payer initiatives, new primary care initiatives, and improvements in birth outcomes;
- Initiated a first-ever national survey of pharmacy costs to aid states in efficiently pricing prescription drugs;
- Built stronger collaborative program integrity activities with states;
- Developed a new template and a streamlined method that enables states to pursue “selective contracting” with health care providers, for example to purchase durable medical equipment in more cost effective ways;
- Established a new website to enhance transparency in 1115 waivers and a waiver template to make it easier for states to apply for a waiver;
- Launched 6 new “learning collaboratives” with states on matters ranging from data analytics to value-based purchasing;
- Clarified flexibilities available to states in how they may structure coverage and payment for children receiving inpatient psychiatric hospital services;
- Provided guidance regarding flexibilities for using Medicaid and CHIP funds to purchase private coverage through plans operating in the Marketplace;
- Provided guidance regarding flexibilities to “benchmark” benefit packages for newly eligible adults to commercial plans;
- Proposed new cost sharing options for states focused particularly on non-emergency use of emergency room services and non-preferred drugs;
- Released guidance and began to provide technical assistance to help states converting current net income eligibility thresholds to equivalent modified adjusted gross income (MAGI) thresholds in Medicaid and CHIP;
- Approved 8 “health home” initiatives qualifying for enhanced federal funding to promote cost effective, integrated care for individuals with chronic conditions;
- Approved 9 state proposals to implement the Balancing Incentive Program which provides additional federal financial support to help states improve and expand access to home and community based long term services and support.

CURRENT OPPORTUNITIES AVAILABLE

As a result of these and other new initiatives, the following new opportunities are available to states to improve care and lower costs; in addition, we continue to welcome new ideas and initiatives proposed by states:

- Without a waiver, states can now implement state-designed integrated care models (ICM)—for example, by tying provider payment to demonstrated saving and improvements in health (page 6). Minnesota became the first state with an approved “ICM” state plan amendment on August 1, 2012.
- States that decide to extend Medicaid coverage to low-income adults can adopt benefit plans for the newly eligible adults that are benchmarked to commercial insurance products as long as they provide Essential Health Benefits. States can adopt different benchmark plans for different populations and can align their benchmark plan with the benchmark that will apply in their individual and small group market. States can also use premium assistance options in Medicaid and CHIP to provide coverage for Medicaid and CHIP-eligible individuals by purchasing coverage through a plan operating on the Marketplace.
- Increasingly, states are extending managed care to long term services and supports. Our new interactive website tool is available now to help states consider ways to move forward in this area (page 10).



- States can take advantage of the information on drug pricing now available on [Medicaid.gov](#); the draft results from the pharmacy pricing survey are posted monthly and the survey will be finalized based on stakeholder input (page 12).
- To strengthen program integrity efforts, states can request CMS resources for targeted auditing (page 14) and they can send staff for free training at the Medicaid Integrity Institute on the latest in program integrity best practices (page 14).
- States interested in lowering cost and improving quality by competitively bidding services that would best be provided by a select group of providers can now do so through a new, streamlined process and waiver template (page 16).
- With the benefit of two years of enhanced federal funding states can develop a **health home** in Medicaid, to improve care coordination for individuals with multiple chronic conditions such as HIV/AIDS (page 9); states can develop these health homes broadly or in more targeted ways and planning funds are available to help states get started. Through the **Integrated Care Resource Center (ICRC)**, CMS is offering technical assistance and support to states in establishing health homes (page 8).
- Enhanced federal funding is also available to states to provide person-centered long term care services and supports to people in their homes and communities through the **Community First Choice** option and the **Balancing Incentive Program** (page 9).
- By using the new section 1115 demonstration template, states can apply for a demonstration to adopt changes in delivery systems or other modifications in the program that further the objectives of the program. (For a description of Oregon’s recently approved section 1115 demonstration establishing care coordination organizations, see page 17).
- New tools and information developed through the work of the six **Learning Collaboratives** are now available for all states. Additional material will be posted as the Learning Collaboratives complete their work on specific items.

ACTIVITY UNDERWAY

- For states interested in implementing integrated care models, additional guidance and tools related to quality measures and shared savings methodology will be released; as always states can bring their ideas directly to CMS.
- New grants will be available for the “Money Follows the Person” Program and to test tools to use in assessing individuals’ functional ability.
- Complementing new proposed rules on cost sharing, additional information will be shared on strategies to reduce unnecessary emergency room use.
- After further comment and testing, a model online application will be available for states to use to implement the Medicaid and CHIP eligibility simplifications in coordination with eligibility determinations for premium tax credits and cost sharing reductions available through the Health Insurance Marketplace, effective in 2014.

- Based on a request for comment, research, testing and consultation with states, a new system for data collection will be launched nationwide in the coming years that will help states, the federal government and all stakeholders rely on a modernized data structure to manage, oversee and improve program services and operations.
- New guidance will be provided on ways states can advance quality improvement as a part of service delivery reform efforts.
- A new web-based system for states doing business with CMS (for state plan amendments, waiver submissions, funding approvals) will be launched to reduce administrative burden and review time and to promote transparency.
- New flexibilities regarding targeted outreach and enrollment strategies will be shared to provide states options for further simplifying the enrollment and retention processes and to address expected increases in enrollment that will result when the 2014 Affordable Care Act changes begin to take effect.

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BACKGROUND

The Medicaid program provides care for millions of Americans, and plays an especially critical role in providing coverage for children, pregnant women, individuals with disabilities and seniors needing long term services and supports. Existing 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 January 2014, coverage rules will be simplified and aligned across insurance affordability programs, and millions of low-income people who are uninsured today will gain coverage.

Because Medicaid is jointly funded by states and the federal government, and administered by states, states and the federal government both 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. Through our daily work with states, and in conjunction with the Center for Medicare and Medicaid Innovation (the Innovation Center) and the Medicare-Medicaid Coordination Office, and agencies across the Department of Health and Human Services, CMS is fostering health care transformation. CMS is 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 will reduce burden while enhancing shared accountability with data-driven performance indicators and more robust and timely data on program operations, expenditures and quality. This report highlights new initiatives launched in 2012 focused on making it easier for states to achieve these goals and provides specific examples of how states are using these tools to advance their own Medicaid and CHIP state initiatives.

The initiatives are organized into two areas:

1. Improving Care
2. Increasing Program Efficiency

IMPROVING CARE

- *Guidance on New State Options for Implementing Integrated Care Models*

Over the past year we've worked closely with several states to design care delivery and payment structures that reward coordinated, high-quality care—referred to as Integrated Care Models (ICMs). These efforts have produced promising models for improving care and lowering costs and have led to the development of guidance for states that wish to adopt or build on such models. In July, we released the first **two letters** to states that discuss the policy considerations for implementing ICMs and describe options available under current Medicaid law and regulations—some for which no waivers are needed—for creating ICMs in a Medicaid fee-for-service environment. These ICMs could include medical homes, Accountable Care Organizations (ACOs), or other outcomes-based strategies, all of which emphasize person-centered, continuous, coordinated and comprehensive care. A new state plan option, described in the letters, makes implementation simpler for states, allowing them to move more quickly in starting these program improvements. We have included in the letters a list of questions for

states to consider as they develop an ICM model, as well as some examples of payment methods.

We plan to issue future guidance about ICM implementation, including letters on shared savings methodologies, quality considerations, and implementation of models within managed care contracts, and other related topics.

In August we approved the first state plan amendment to implement the new option for integrated care models. Minnesota's care model will link patient outcomes and experience to payments, and hold providers accountable for care delivered by sharing in savings and losses for the total cost of care.

■ *Increased Payments will Improve Access to Primary Care*

In November, we issued a final rule to implement an Affordable Care Act provision that provides for increased payments to primary care physicians. Medicaid payment rates for primary care services will be increased to the Medicare rates in calendar years 2013 and 2014, with 100% of the increased cost paid by the federal government. This increase will help providers prepare to serve the millions of Americans who will become newly eligible for Medicaid in 2014. Family medicine physicians, general internal medicine physicians, and pediatricians will qualify for the increased payment. And as of January 1st of this year, providers providing preventive care are eligible for enhanced reimbursement for preventive care services. Health homes and other integrated care models will also maximize the abilities and capacities of Medicaid primary care providers. These efforts, as well as other Affordable Care Act initiatives including the Comprehensive Primary Care Initiative described below, new community health centers, increases in primary care residency slots, and physician assistant and nurse practitioner training and the National Health Service Corps will help bolster our abilities to provide quality primary care to all who need it. CMS has developed a tool for how states can apply the primary care payment in a capitated managed care delivery system. CMS also continues to provide states, providers and other stakeholders with Question and Answer documents on these increased payments that answer some of the frequently asked questions we receive.

■ *Better Coordination of Care for Medicare-Medicaid Enrollees*

Today, more than 10.1 million Americans are enrolled in both the Medicare and Medicaid programs. Two-thirds of these Medicare-Medicaid enrollees are low-income elderly and one-third are people who are under age 65 with disabilities. As enrollees of two separate programs, these individuals and their health care providers must navigate multiple sets of rules and coverage requirements and manage different identification cards, benefits, and plans. Their care often is fragmented or episodic, resulting in poor health outcomes for a population with significant, complex needs. Dual program eligibility also leads to misaligned incentives, resulting in cost shifting, unnecessary spending, and inefficient administration.

We've announced several new opportunities—through our new **Medicare-Medicaid Coordination Office**—designed to improve the overall beneficiary care experience and coordination of services for Medicare-Medicaid enrollees. First, the Medicare-Medicaid Financial Alignment Demonstration provides an opportunity for states and CMS to partner and

test integrated care programs by aligning the service delivery and financing of the programs to improve both the quality and costs of care (see the highlighted box below for more information). Supplementing this effort, in February 2012 we launched a new initiative that works to better coordinate care for Medicare-Medicaid enrollees who live in nursing facilities and reduce costly and disruptive avoidable hospitalizations (see the description of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents in the Funding Opportunities section below).

Better Care Coordination for Medicare–Medicaid Enrollees

23 states are working with CMS' new Medicare-Medicaid Coordination Office to develop and test demonstrations to improve care for Medicare-Medicaid enrollees and lower costs by better aligning service delivery and financing across both Medicare and Medicaid. The first demonstrations will be implemented in 2013.

To further this work, CMS created a new Integrated Care Resource Center, to provide states with support and technical assistance to better coordinate care. In addition, we created a new process to help states access Medicare data to support care coordination and improve quality. Most recently, we released **Medicare-Medicaid enrollee state profiles** to foster a greater understanding of program utilization, characteristics, and spending patterns, to support and strengthen program development.

Louisiana is using other state plan authorities to share savings with a Primary Care Case Management Entity. This partnership allows beneficiaries to receive more coordinated care and is driving down costs for the state and providers.

■ *New Opportunities for States to Improve Long Term Services and Supports*

In 2012, CMS helped many states make significant progress in improving care for individuals who count on long term services and supports (LTSS). This

Payment System Reform—Improving Care and Lowering Costs

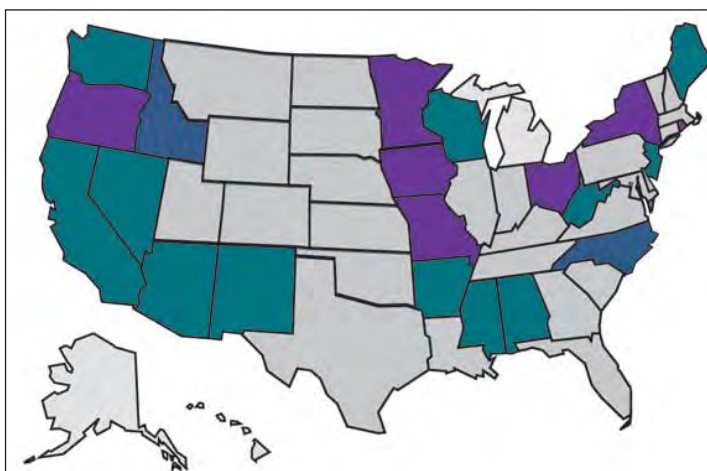
Under a state plan amendment effective October 1, 2012, Arkansas will reward providers who deliver high-quality, coordinated and cost-effective care on some of the most expensive episodes of care. The initiative will begin with conditions like upper respiratory infections (URI), total hip and knee replacements and congestive heart failure (CHF). Providers will initially be paid under the existing fee-for-service arrangements, but once data is available on spending and quality, providers will become accountable for the cost and quality of the care, sharing in the savings they create. Arkansas remains a leader in quality, recently announcing significant savings in their Medicaid program, even as enrollment and quality efforts increase.

included opportunities that allow these individuals to live and work in their communities near loved ones and friends. It also included help for states seeking to utilize managed care in an effort to coordinate acute services along side LTSS. Improvements in coordinating care can greatly improve quality of life for these beneficiaries and significantly reduce the cost of care.

Community First Choice: The program provides an incentive for states to expand their Medicaid coverage for person-centered home and community-based attendant services and supports. States that elect the Community First Choice option are eligible for a 6 percentage point increase in their federal medical assistance percentage. Individuals who require an institutional level of care are eligible for the services, which will be offered in community-based settings. The program allows individuals to “self-direct” services, which affords individuals maximum choice and control over the services they receive. States may also choose to provide coverage for transition costs to assist Medicaid beneficiaries who are leaving institutions in transitioning to the community. The program also includes protections are in place to ensure quality care for individuals in the program.

Balancing Incentive Program/ Money Follows the Person: The Balancing Incentive Program was created by the Affordable Care Act to authorize grants to states to increase access to non-institutional long term services

Medicaid Health Homes—New Resources to Support Coordinated Care



8 states have implemented Health Homes to improve care coordination for Medicaid beneficiaries with chronic conditions under the state plan option created by the Affordable Care Act: **IA, ID, MO, NC, NY, OH, OR, RI.**

17 states have received Health Home Planning grants: **AL, AR, AZ, CA, DC, ID, KS, ME, MN, MS, NV, NJ, NM, NC, WA, WV, WI.**

Iowa’s Health Home Program: Iowa’s program targets individuals who have two of the following chronic conditions (or have one and are at risk for a second): mental illness, substance abuse disorder, asthma, diabetes, heart disease, obesity, and hypertension. As an individual’s number of chronic conditions increases, the individual’s risk avoidable hospitalizations, receiving conflicting advice from physicians and other health care providers increases. Health homes provide coordinated care for all of a beneficiary’s health needs and ensure that each individual has an ongoing relationship with a provider.

and supports (LTSS) as of October 1, 2011. The Balancing Incentive Program will help states transform their long term care systems by lowering costs through improved systems performance and efficiency, creating tools to help consumers with care planning and assessment, and improving quality measurement and oversight.

The Money Follows the Person Rebalancing Demonstration Program (MFP) helps states rebalance their long term care systems to transition people with Medicaid from institutions to the community. The goals include increasing the use of home and community-based services (HCBS) and reducing the use of institutionally-based services, eliminating barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to allow beneficiaries to receive long term care in the settings of their choice, and establishing procedures to provide quality assurance and improvement of HCBS. The Affordable Care Act strengthens and expands the “Money Follows the Person” Program to more states.

Moving Care to the Community

Under the Affordable Care Act’s Balancing Incentive Program, states can qualify for extra federal funding if they increase access to LTSS in the community, rather than an institution. New Hampshire, Maryland, Georgia, Mississippi, Missouri and Iowa were awarded Balancing Incentive Program grants.

New Website to Support Managed Care:

Many states are expanding their managed care programs to deliver care to people with disabilities and seniors, and are including the long term services and supports these beneficiaries need. To help states design and implement models that meet their needs and ensure appropriate care and beneficiary protections, CMS created a website featuring a **comprehensive online training curriculum** for states that are considering developing managed long term services and supports (MLTSS) programs. Stakeholders and advocacy groups can use this tool to learn more about ways to strengthen this new way of delivering services. Key website elements include videos about successful program models, and tools such as checklists, contract samples, and case studies related to a variety of topics, such as MLTSS basics, approaches to stakeholder engagement, person-centered approaches, and quality management.

■ *Funding Opportunities for States and Others Serving Medicaid and CHIP Beneficiaries*

In 2012, we announced several new funding opportunities to help states to improve health and lower costs. Along with states, health systems and other health providers, we’re making strategic investments in activities that will yield improvements in patient care and ultimately help to improve health and drive down costs in the healthcare system:

- **State Innovation Models (SIM) Initiative**—supports states’ efforts—through their Medicaid programs and public health departments (among other avenues)—to develop and/or test new multi-payer models that reduce costs and improve quality for their residents, including through integrate integrating community-based health and reducing long term health risks for Medicare, Medicaid, and CHIP beneficiaries.

- Comprehensive Primary Care Initiative**—provides 500 participating primary care practices a care management fee to support enhanced, coordinated services for their patients, including Medicare and Medicaid beneficiaries. Insurers in seven markets—Arkansas, Colorado, New Jersey, Oregon, New York’s Capital District-Hudson Valley Region, Ohio’s and Kentucky’s Cincinnati-Dayton Region, and greater Tulsa, Oklahoma—will participate in this. Medicaid programs are participating, directly as an insurer and indirectly through their managed care plans, in all seven areas.
- Health Care Innovation Awards**—provides funding to entities who have proposed to implement the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP, particularly those with the highest health care needs. These 107 projects, according to awardees’ projections, could save the health care system an estimated \$1.9 billion over the next three years.
- Strong Start for Mothers and Newborns**—an effort to improve birth outcomes for mothers and infants across the country, and in particular for those enrolled in Medicaid. Strong Start has two strategies. The first is a test of a nationwide public-private partnership and awareness campaign to spread the adoption of best practices and supports for providers in reducing early elective deliveries prior to 39 weeks. CMS is partnering with the March of Dimes and the American Congress of Obstetricians and Gynecologists, among others, to produce resources like the **Strong Start Toolkit** for providers and consumer organizations towards this goal. The second strategy tests three enhanced prenatal care models aimed at reducing the rate of pre-term births for Medicaid beneficiaries who are at-risk of pre-term birth. \$41.4 million was made available to fund enhanced prenatal care interventions. Strong Start awardees will be serving women in the areas with the highest pre-term birth rates in the country, including areas that are among the top ten prematurity and infant mortality counties according the Centers for Disease Control and Prevention.
- Grants to States for Quality Improvement**—provides an opportunity for Medicaid agencies in participating states to receive up to \$2 million each for collecting, reporting, and using the Initial Core Set of Health Care Quality Measures for Medicaid-eligible Adults. Through this opportunity, states will make investments towards evidence-based quality health care with the reporting of the adult core-health quality measures to CMS. This support will better position states to realize the value of these data for program management and for improving care and health outcomes of adults in Medicaid. On December 21, 2012, CMS selected twenty-seven states to participate in this grant program.

Delivery System Reform

Under the CMS Emergency Department (ED) Diversion Grants, a project in Pennsylvania linked patient navigators with persons with serious mental illness to reduce non-urgent ED use. Patients are encouraged to use an integrated care site that could care for their primary and behavioral health needs. The project reported a 31% reduction in ED visits for individuals with the most serious acuity level.

- **Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents**— supports organizations that will partner with nursing facilities to implement evidence-based interventions that both improve care and lower costs. The initiative is focused on long-stay nursing facility residents who are enrolled in the Medicare and Medicaid programs, with the goal of reducing avoidable inpatient hospitalizations. This initiative supports the Partnership for Patients' goal of reducing hospital readmission rates by 20% by the end of 2013. Nursing facility residents often experience potentially avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive, and disorienting for frail elders and people with disabilities. Nursing facility residents are especially vulnerable to the risks that accompany hospital stays and transitions between nursing facilities and hospitals, including medication errors and hospital-acquired infections. Funds were awarded to entities in Alabama, Indiana, Nebraska, Nevada, New York, Pennsylvania and Missouri.

INCREASING PROGRAM EFFICIENCY

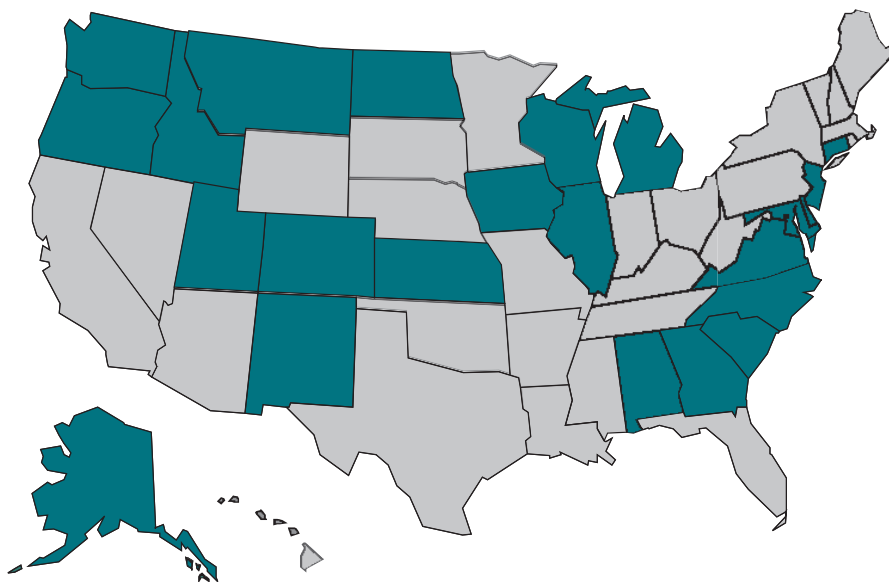
■ *Pharmacy Survey to Aid States in Efficiently Pricing Prescription Drugs*

In an effort to increase transparency in drug pricing and help states determine appropriate payments to pharmacies, we began a major, new national Medicaid drug survey of pharmacy acquisition costs in June 2012. This monthly survey gathers information on acquisition costs of covered outpatient drugs purchased by retail community pharmacies including independent community pharmacies and chain pharmacies. This information, the National Average Drug Acquisition Cost (NADAC), is currently being posted in draft format on Medicaid.gov. We are also collecting state payment and utilization rates, and comparing state drug payment rates for the 50 most widely prescribed drugs with the national retail sales price data. In addition, we are posting a monthly report, in draft, on the national average retail prices (NARP) reflecting the results of a nationwide retail survey of consumer prices for prescription drugs, which is available on Medicaid.gov. The survey results will help states determine their reimbursement methodology to ensure efficient outpatient drug purchasing.



Connecting Kids to Coverage: CHIPRA Performance Bonus Awards

In December 2012 CMS awarded nearly \$306 million in performance bonuses to 23 states. States were rewarded for adopting sustainable improvements that are known to enhance health coverage program access for eligible children.



Highlights:

- Colorado earned the highest bonus of any state—\$43 million. This year, Colorado began implementing Administrative Renewal—a process for verifying a child’s continued eligibility electronically that will be adopted nationwide for most of those eligible for Medicaid and for CHIP effective 2014.
- South Carolina first adopted Express Lane Eligibility (ELE) in 2011, using SNAP and TANF data to easily renew coverage for children. In 2012, the state augmented its use of ELE procedures and has enrolled about 63,000 eligible children already receiving SNAP and TANF.

The draft methodologies for calculating NADAC and NARP are posted and we continue to collect **public** comments and feedback on the methodologies and result files and plan to post comments and responses on our website. Once posted, we expect to finalize these documents, incorporating the applicable stakeholder suggestions, and move from draft to final format.

■ *Redesign of the National Medicaid Audit Program*

We have implemented a redesign of the **National Medicaid Audit Program** and are working with states to expand the use of collaborative audits. Collaborative audits allow CMS to work alongside states to identify areas that need further investigation. Through this process CMS can more effectively support a state’s program integrity efforts. Since the earliest collaborative audits in 2010, CMS has worked with 22 states whose combined expenditures represent approximately 60% of all Medicaid expenditures, to undertake a total of 218 collaborative audits. CMS is committed to expanding collaborative audit projects more broadly, and expects to have collaborative projects with 30 states by the end of FY 2013.

As part of this initiative, CMS is also modifying our approach to the Medicare-Medicaid data match program known as “Medi-Medi.” The Medi-Medi program gives states the opportunity to work closely with CMS, our benefit integrity contractors, law enforcement, and other partners in the effort to curb Medicaid fraud, waste and abuse.

CMS is also exploring with states how best to apply to Medicaid the predictive modeling and other advanced analytics CMS has developed for Medicare through the Fraud Prevention System. In addition we are partnering with states to test the use of the new CMS Medicare Automated Provider Screening technology.

■ *Medicaid Integrity Institute (MII)*

We continue to expand our efforts to support state program integrity through education and training at the **Medicaid Integrity Institute (MII)**. The MII provides training for state program integrity employees at no cost to the state. The Medicaid Integrity Institute (MII) has been credited by states, Congress, the Government Accountability Office (GAO), and Medicaid and CHIP Payment and Access Commission with making a substantial contribution to state efforts to combat fraud and improper payments. The MII has trained 3,383 state employees from all 50 states through 82 courses from its inception in 2008 through the end of FY 2012, with 919 state staff participating in 19 courses in FY 2012 alone. Attendees are able to learn and share information with program integrity staff from other states.

In FY 2013, CMS will enhance the educational opportunities provided through MII by expanding course offerings, providing distance learning through monthly webinars to train even more



state program integrity staff, and issuing the first Certified Program Integrity Professional designation for state program integrity staff who successfully complete certification requirements. In addition, MII supports a secure, web-based information sharing system that all states use to exchange documents, questions and answers, tips, and best practices about Medicaid program integrity under the auspices of the Bureau of Justice Information Assistance. MII classes and programs are available to state officials without charge.

■ *CMS Provider Screening Innovator Challenge*

In May 2012, we launched the **Provider Screening Innovator Challenge**, a competition to develop a multi-state, multi-program software application to help states screen providers who want to enroll in Medicaid. The application will have the capability to score risk, validate credentials, authenticate identity, and complete sanction checks to help states keep potentially fraudulent providers out of Medicaid. It is also expected to lower the administrative burden on providers and reduce administrative and infrastructure expenses for state and federal programs. To date, we have conducted approximately 120 contests and expect to conduct an estimated 20 more within the next two months to complete the overall Challenge effort.

■ *Template to Allow States a Streamlined Method for Selective Contracting*

Generally, Medicaid law requires that in a fee-for-service environment, “any willing provider” be permitted to provide services to Medicaid beneficiaries. Federal law permits state Medicaid agencies,

Since we made available 90% matching funds for upgrades to eligibility and enrollment systems that meet high standards:

- 48 states, the District of Columbia, and the U.S. Virgin Islands have submitted Advanced Planning Documents requesting enhanced funding for eligibility and enrollment systems.
- 44 states and the District of Columbia have received approval from CMS for enhanced funding; 4 requests are under review.
- CMS has approved \$1.5 billion in federal matching funds.

States also have access to an A-87 waiver that allows states to receive enhanced federal funding for building systems within the human services programs that work with and along side their Medicaid programs.

For example:

- NC is further automating and modernizing its eligibility determination systems including ePASS, a secure and web-based self-service tool, to enable beneficiaries to maintain an electronic account they can access online.
- MT is integrating its Medicaid and CHIP eligibility systems; the new eligibility system will be web-based and user friendly. It will coordinate with the Marketplace and further support interoperability and data exchange with private insurers, the state insurance commissioner, and federal interfaces.
- OK has created an integrated eligibility and enrollment system that allows multiple state agencies to communicate with one another to determine eligibility. The system gives Oklahomans 24/7 access to an eligibility system that is digital and no longer reliant on physical structures. It also allows individuals and families to get real time results when they apply. An independent evaluation of Oklahoma’s system has projected that, thanks to these modernizations, between 2011 and 2015 the state will save over \$22 million in state funds.

under certain circumstances, to contract with a limited number of providers to deliver a service covered under the state plan in order to improve the efficiency of the state's purchasing. For example, a state may want to negotiate a special purchasing arrangement for durable medical equipment or specialty pharmacy items. The process for securing a "selective contracting waiver," however, has been viewed by states as particularly burdensome. To streamline the process for states seeking such waivers, in August, we issued a **revised template** for states. The template collects only necessary information in a standardized, transparent format. Minnesota was the first state to utilize this new flexibility, and we expect others will soon. The application and accompanying technical guide are intended to make it easier for states interested in improving the efficiency of their purchasing to secure a waiver, while ensuring beneficiaries have appropriate access to quality services.

■ *New Waiver Template to Ease the Process for State Applications for Section 1115 Waivers*

Section 1115 demonstrations can introduce new approaches to Medicaid service delivery and financing that can provide new models and lead to positive changes to the program nationwide. Because of the important role demonstration projects can play, the Affordable Care Act made changes to the state and Federal review processes to ensure transparency and public input. In April, we launched a new section of the Medicaid.gov website to help make the 1115 demonstration review process more transparent to states and stakeholders. The site provides an **online forum** for public comment, and allows states to easily identify demonstrations approved in other states, along with accompanying documentation. The site also allows stakeholders to have a real-time view into states' proposals. We hope these improvements will facilitate states' ability to build on the innovations of their peers. Also, we released a section 1115 demonstration template, for states to use in order to simplify the waiver application processes and make it easier for states to design and gain approval for demonstrations.

The **Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs** provide incentive payments to eligible professionals, hospitals, and critical access hospitals as they adopt, implement, upgrade, or meaningfully use certified EHR technology in ways that improve care.

- By the end of December 2012:
- Approximately 70 percent of all eligible hospitals in the U.S. have received an incentive payment.
- More than one in three Medicare and Medicaid eligible professionals in the U.S. has received an incentive payment.
- Forty-nine states and Puerto Rico are participating in the Medicaid EHR Incentive Program.
- More than \$4.4 billion in Medicaid EHR Incentive Program payments have been awarded.

CONCLUSION

System delivery changes, payment reforms, and innovations, including changes involving other payers, have taken hold in the Medicaid program to promote high-quality care for its beneficiaries. Medicaid is a full partner in broader health system changes aimed at driving improvements in care while lowering costs. Changes are also in progress for Medicaid's new role starting in 2014 such as: new flexibilities for benefit design, proposed cost sharing changes, modernized eligibility and enrollment systems to support the implementation of income-based eligibility rules, and a data-driven online application and renewal process. We value ongoing partnership with states, beneficiaries, consumer advocates and health care providers in this important work. Please continue to send ideas and suggestions to MedicaidMovingForward@cms.hhs.gov.

In July 2012, CMS approved an 1115 demonstration amendment in Oregon that will support the state in launching Coordinated Care Organizations (CCOs) for beneficiaries across the state. These managed care entities are now actively coordinating all of a beneficiary's care—physical and behavioral—and rely on new care delivery models with focus on lowering costs through improving care. The CCOs have enhanced local governance, engagement in a range of specific activities to improve quality and access, and provide payment structures that promote transparency and accountability for improved outcomes. And in December 2012, CMS and Oregon agreed on the criteria that will measure progress in meeting the demonstration's cost, quality, and access goals.

