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Managing a High-Performance Medicaid Program

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Executive Summary

Today, the Medicaid program is evolving more rapidly than at any other time in its fifty-year history. States and the federal government are working to maximize the value and efficiency of Medicaid by reforming payment to reward value over volume, integrating effective care coordination across payers, and streamlining key processes like eligibility determinations across coverage programs. Underpinning a state's ability to implement these reforms is its capacity to manage its Medicaid program effectively and efficiently.

This paper discusses key responsibilities that the federal government and states hold for managing the Medicaid program and identifies the key issues and challenges states face as they transform the way they do business and achieve key national goals. The paper relies on an extensive review of federal and state responsibilities drawn from statute, regulation, and relevant literature, coupled with discussions with six current Medicaid directors, who graciously volunteered their time and observations on the opportunities and challenges they face in administering their state Medicaid programs.

Federal and state governments share responsibility for administering Medicaid.

States operate the Medicaid program within broad federal guidelines in partnership with the federal government. The federal government, through the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, is responsible for interpreting federal law and policy, which sets the parameters within which states operate Medicaid. CMS approves state policy design choices by approving state plans and waivers, ensures that federal matching payments are made appropriately, and monitors and enforces state compliance with federal rules. Overall, working with states, CMS is responsible for ensuring the effective and efficient administration of the Medicaid program.

States assume front line, day-to-day responsibility for the actual operations of each state's Medicaid program. States make key administrative decisions, such as determining what agency or agencies will administer the Medicaid program, and paying for Medicaid services, as well as a wide range of policy design decisions. States elect which populations and services above the federal minimum standards to cover and determine the scope of covered benefits. They determine individual eligibility for Medicaid and ensure that beneficiary protections are met. States define and, in some cases, develop the delivery system that will provide care for Medicaid beneficiaries, including which providers may participate and how much they may be paid and whether and how to contract with managed care organizations to deliver care. States also ensure the quality and cost-effectiveness of care.

States and the federal government must administer Medicaid within the context of tight budgets and limited resources. The recent recession put intense strains on both federal and state budgets. All states but one have a constitutional obligation to balance their budgets, making it difficult for Medicaid programs to respond to unexpected costs and increased enrollment. At the federal level, there has been intense debate about options for federal deficit reduction.

Medicaid's responsibilities go significantly beyond those of other insurers and programs.

Medicaid covers more than 66 million Americans, making it the largest single health insurer in the United States. While the responsibilities of a state Medicaid program overlap with those of any other health insurer, as a public agency, that scope is broader. State Medicaid programs serve a state's most socially and medically vulnerable, providing a broader scope of services than that covered by a typical health insurer. As a public agency, a state Medicaid program must also consider its impact on the health and well-being of the state's population, the health care delivery system, as well as the state's economy and budget.

Medicaid is evolving and faces a set of new opportunities and challenges.

States and the federal government are trying a number of approaches designed to better manage costs, increase value to consumers and improve the health of populations. Bending the cost curve, both to ensure the best health care value for the dollar and to manage fiscal pressure, is a shared central state and federal goal, and stronger efforts to collect and report quality and program performance data support that goal.

At the same time, with the implementation of the Affordable Care Act, states are establishing new coverage options for their residents through Medicaid and the Health Insurance Marketplace (Marketplace). States are working with CMS to redesign the policy, processes, and systems that determine eligibility for most of their populations while ensuring that these new policies and systems coordinate with Marketplace coverage and coverage for other health programs like CHIP.

Like other health insurers, in the past Medicaid operated as a relatively passive purchaser, focusing on paying provider claims and the other routine administrative tasks of an insurer. However, as Medicaid has matured and evolved, it, like most health insurers in the US, has shifted toward a more active role as purchaser, establishing performance and outcome-based goals in order to maximize the value of health care purchased for the Medicaid dollar.

Adequate administrative capacity is key to realizing the goal of running a high performing Medicaid program.

How states and the federal government manage their programs underpins Medicaid performance, as well as the degree to which Medicaid's resources are managed efficiently. Administrative capacity includes at least three key elements:

» **Resources sufficient to manage a large, 21st century program**. Medicaid now covers over 66 million and in FY 2011, total Medicaid spending excluding administration totaled about $414 billion.[1] For a program of this magnitude administrative funding and staffing need to be adequate to ensure effective management of the Medicaid program. However, over the past several years state budget cuts have meant reductions in state-level funding and staffing. As a major component of a state budget, the Medicaid program is often a primary target for budget cuts, although cuts are often made to the administrative capacity needed for managing the programs, rather than the programs and services themselves. Staff furloughs have been a common strategy for managing administrative funding reductions. While budget reductions have leveled off in recent years, increased investment in funding and staffing Medicaid agencies has been limited. Similar budget constraints at the federal level have had an impact on CMS staffing as well.

- **A skill set that emphasizes leadership, policy design, operations, and analytics.** Possessing the right skills at both the leadership and staff level are essential to achieving a high-performing Medicaid program. At the leadership level, state Medicaid directors establish a strategic vision for the agency, oversee day-to-day operations to support that vision, manage legislative and stakeholder relationships, and ensure accountability. State agency staff develop policy and programs, manage large contracts, oversee operations, budget and finances and ensure quality and performance. To do this successfully, state staff need policy design skills, policy and data analytics, experience in managing personnel and contracts, and skills to ensure effective management and oversight. States compete with private entities for the people who possess these skills in a highly competitive marketplace, where the demand for health care talent is currently high.
- **Systems developed to support performance**. Systems support nearly every day-to-day transaction that Medicaid undertakes, and their performance underpins the efficiency of the program. Systems handle routine transactions quickly and efficiently, freeing staff to focus on more complex tasks. They also gather data and serve as the basis of the data analytics that have become central to measuring and ensuring the performance of each health insurance program and the health care system as a whole.

Responsibility for ensuring that states have adequate capacity to manage their Medicaid program resides at both the state and federal level. With the support of the federal government, states are responsible for ensuring the adequacy of their own resources and ensuring the adequacy of their internal processes. Unfortunately, the natural forces of the state budgeting process often work against state investment in a Medicaid program's administrative capacity, at the same time that the complexity of managing a Medicaid program has only increased over time. Inadequate investment in Medicaid administrative capacity could undermine a state's ability to fulfill its responsibilities under federal and state law, as well as its ability to achieve the most from this important program.

Introduction

Created in 1965, Medicaid began as traditional medical coverage offered as a public welfare benefit to certain low income families and individuals. While the Medicaid program has steadily evolved over the years, it still has many of the core functions of a typical health insurer including:

- Implementing beneficiary protections and safeguards
- Enrolling beneficiaries
- Managing utilization
- Enrolling providers
- Negotiating and setting provider payment
- Budgeting and managing expenditures
- Measuring and managing program performance and quality

Today, in large part due to the Affordable Care Act, the Medicaid program is evolving more rapidly than at any other time in its history. Fueled by innovations promoted under the Affordable Care Act, many state Medicaid programs are transforming the way they do business, driving payment and delivery reforms aimed at bending the cost curve. By shifting their focus from claims processing to health care purchasing, Medicaid agencies are working to hold managed care organizations and providers accountable for the quality of the services provided, rewarding value over volume. At the same time, the Affordable Care Act has expanded the role of state Medicaid programs, allowing

states to expand coverage and requiring states to simplify and coordinate the eligibility and enrollment process for Medicaid with eligibility and enrollment in the new Health Insurance Marketplace (the "Marketplace") to be launched in 2014.

While state Medicaid programs are called upon to become more sophisticated health care purchasers, they operate under a very different set of rules from other insurers and have a broader scope of responsibility. For example, unlike other health insurers, they are responsible for:

- Providing coverage to a state's most socially and medically vulnerable.
- Covering a broad range of services, including social services and long term services and supports.
- Providing access to care to all entitled to coverage under eligibility criteria.
- Determining financial eligibility before applicants may be enrolled.
- Considering the impact of Medicaid policy on the state budget, the state economy, and the health and well-being of the state's population and delivery system.

In addition, competition for access to billions of dollars of Medicaid financing also subjects Medicaid policy choices and purchasing decisions to heightened scrutiny and procedural requirements designed to ensure fairness and compliance with public intent. As a result, Medicaid policy is subject to the approval of the federal government and the involvement of state legislatures, governors, beneficiaries and other stakeholders. Medicaid program decisions are often subject to judicial rulings which can have a significant impact on a Medicaid agency's range of discretion. Court decisions and CMS interpretations and guidance can also have an impact on a Medicaid agency's budget. Medicaid programs must account for expenditures to the state legislature and the federal government. Medicaid agencies are also accountable for the use of Medicaid funds for services and programs administered by sister agencies and local governments. Medicaid administrators must make staffing and contracting decisions in compliance with civil service codes, collective bargaining agreements, state procurement regulations, and sometimes court orders.

Because a state Medicaid program combines the functions of a health insurer with the responsibilities and accountability of a public welfare agency, Medicaid program administration requires a unique combination of skills and expertise. These skills and expertise range from the business skills necessary for operating a large health plan, to the policy expertise and political skills needed for communicating and collaborating with others within state government, the state legislature, the federal government and a range of other stakeholders, to the strategic expertise and skills that allow the Medicaid program to anticipate and respond to an ever-changing fiscal, policy and political environment.

Because state Medicaid programs vary in terms of resources, organizational structure and program design the current administrative capacity to administer these programs also varies. While all states face new opportunities and challenges that arise from the implementation of the ACA, the ability to successfully handle these changes will depend on how robust or how depleted the current administrative capacity for Medicaid is.

This paper discusses key responsibilities that the federal government and states hold for managing the Medicaid program and identifies the key issues, challenges and administrative capacity needs that face states as they aim to transform the way that they do business and achieve key national goals. The paper relies on an extensive review of

federal and state responsibilities drawn from statute, regulation, and relevant literature, coupled with discussions with six current Medicaid directors, who graciously volunteered their time and observations on the opportunities and challenges they face in administering their state Medicaid programs.

Federal and State Governments Share Responsibility for Administering Medicaid.

Federal and state governments share responsibility for administering Medicaid. In general, the federal government establishes the parameters within which state Medicaid agencies must operate and then monitors state performance. The federal government is responsible for interpreting the Social Security Act and related federal statutes, enforcing compliance, reviewing state plan amendments and waivers, ensuring proper and efficient management of the program, promoting program integrity and development and use of quality and performance standards. States that participate in Medicaid must comply with broad federal requirements, but then have broad flexibility in how to administer and design their programs. As a result of this flexibility, there are 55 unique Medicaid programs across all fifty states, four territories, and the District of Columbia. The following section outlines key federal and state responsibilities for administering the Medicaid program.

Table 1. The Distribution of Federal and State Responsibilities for Medicaid Program Administration

Federal Responsibilities and Authorities	State Responsibilities and Authorities
Program Organization & Design	***Program Organization & Design***
• Interprets Federal Statutory Requirements	• Designates a Single State Agency
• Reviews State Plans & Waivers	• Defines Covered Populations and Benefits
	• Sets Payment Rates and Design Delivery Systems
Program Operations	***Program Operations***
• Ensures Proper and Efficient Administration of the Program	• Claims Federal Financial Participation
	• Determines Eligibility
Promotes and Ensures Program Integrity	• Manages Utilization
Promotes and Manages Quality and Performance	• Implements Beneficiary Protections
	• Manages Provider Payment
	• Collects and Report Program Information
	Promotes and Ensures Program Integrity
	Promotes and Manages Quality and Performance

Program Organization and Design

FEDERAL ROLE

The federal government, through the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, is responsible for interpreting federal law and policy, which sets the parameters within which states operate Medicaid. CMS approves state policy design choices by approving state plans and waivers, ensures that federal matching payments are made appropriately, and monitors and enforces state compliance with federal rules. The Social Security Act holds CMS responsible for ensuring the effective and efficient administration of the Medicaid program though its oversight of state Medicaid programs.

Interprets Federal Statutory Requirements and Enforces Compliance

The Secretary has broad authority to promulgate rules "not inconsistent with [the Social Security Act], as may be necessary to the efficient administration" of its responsibilities.[2] In some cases, Congress directs the Secretary to promulgate rules and in other cases it is silent. CMS also uses policy guidance in the form of letters to state Medicaid directors, letters to state health officials, and informational bulletins to disseminate its interpretation of the law. State Medicaid director letters and informational bulletins include operational and technical information to help states implement new regulations and policy. CMS' interpretation of the law can also be translated into technical and operational form through state plan amendment or waiver templates, and other tools produced for state use.[3] CMS' interpretation of federal law is also reflected in the negotiated terms and conditions governing §1115 demonstration waivers, in competitive grant solicitations, and the resulting agreements governing those demonstrations.

Reviews State Plan Amendments and Waivers

CMS is responsible for approving each state's Medicaid program as described in its state plan, amendments to its state plan, and the terms and conditions of any waiver of state plan requirements. Federal regulations give the regional administrator of CMS authority to approve state plan amendments although in practice the approval process may involve CMS' central office and HHS. The CMS central office administrator has authority to disapprove a state plan amendment, in consultation with the Secretary.[4]

The federal government also reviews state waiver applications. Sections 1915(b) and 1915(c) are "program waivers;" §1915(b) allows states to restrict a beneficiary's free choice of provider and provide services through capitated managed care[5] and §1915(c) allows states to limit access to home and community-based services (HCBS) to specific target groups requiring an institutional level of care and to cap enrollment in the HCBS program. The conditions and process for obtaining CMS approval of these program waivers is routine and relatively formulaic. CMS may grant an §1115 waiver to carry out an experimental, pilot or demonstration project likely to assist in promoting the objectives of Title XIX. Section 1115 has been used for wide range of purposes including testing new ideas, expanding health coverage, or implementing comprehensive reform. These waivers generally entail significant negotiations with states. For each waiver authority, CMS must ensure that the waiver does not increase federal expenditures, although the standard for measuring the impact on federal expenditures (cost effectiveness, cost neutrality and budget neutrality) varies across the three authorities.

CMS has used §1115 and other authorities to support innovation and program reform. Through Independence Plus, Real Choices Systems Change and Money Follows the Person competitive grant opportunities and waiver templates, CMS has encouraged states to offer home and community-based services as an alternative to institutional services for persons with disabilities and older adults. More recently, the Affordable Care Act created the Center for Medicare & Medicaid Innovation (CMMI) with new demonstration authority, §1115A, for promoting payment and delivery system reform.[6] Thirty-five states are currently participating in 55 payment and delivery system reform initiatives administered by CMMI.[7]

STATE ROLE

States make programmatic decisions within federal parameters and assume front line, day-to-day responsibility for the actual operations of each state's Medicaid program. States make key program organization and design decisions as well as operational decisions. To a large extent the choices a state makes about the design of its program drive

the administrative capacity a state needs to manage its program. For example, different decisions about covered populations, covered services and delivery system design may shape how the Medicaid program interacts with other state agencies, managed care organizations and providers; a decision to implement managed care triggers a range of federal regulatory requirements and can redefine Medicaid staff responsibilities; and how a state chooses to organize the eligibility determination process also has implications for program staffing and organizational relationships with other governmental units.

Designate a Single State Agency

Each state must identify a single state agency responsible for administering or supervising the administration of the Medicaid program. Depending on the relationship to other government agencies, some responsibilities may be delegated to other state agencies, or to a county, regional or municipal government.[8] The single state agency must have authority to make rules and regulations governing the administration of the Medicaid program and its authority may not be subject to the authority of another state agency.[9] Within the single state agency, the state must have a medical assistance unit responsible for the development, analysis and evaluation of the Medicaid program.[10]

The Medicaid agency is responsible for determining eligibility or it may delegate that responsibility to the single state agency responsible for TANF, or to the federal agency administering the SSI program for determining eligibility for older adults, blind or persons with disabilities.[11] It may also establish "outstations" for assisting applicants with the application process and receiving applications and related documentation; the Medicaid agency may also co-locate state eligibility staff at the outpost for evaluating applications and determining eligibility.[12] Many states delegate eligibility and enrollment to a sister agency or county governments.

A state may also choose to contract out certain Medicaid program functions.[13] For example, states may contract for the operation of its Medicaid management information system (MMIS) or its third party liability (TPL), which secures reimbursement from any other insurers responsible for coverage to beneficiaries.[14] (Only 12 states have not contracted with another entity to operate their MMIS.[15])

Define Covered Populations[16]

In its early years, Medicaid eligibility was tied to eligibility for welfare programs and included low-income families, older adults, persons who are blind, and persons with disabilities receiving cash assistance. Over time, minimum Medicaid eligibility has expanded, particularly for children and pregnant women. Today these mandatory groups include children, pregnant women, parents, older adults, and persons with disabilities, up to minimum income thresholds. (For older adults and persons with disabilities, eligibility is tied to eligibility for Supplemental Security Income (SSI).) In addition, states have the option to extend Medicaid eligibility above these minimum financial thresholds, to persons falling into one of these eligibility categories. One group that has historically been excluded from the core federal groups is non-disabled adults without dependent children. The ACA calls for an expansion in Medicaid eligibility to 138% FPL for nearly all non-elderly and non-disabled adults; pursuant to the 2010 *NFIB v. Sebelius* Supreme Court decision, expansion to this group is optional. Prior to enactment of the ACA, adults not falling into any of these categories (*i.e.*, adults younger than age 65, without children, not pregnant, and not having a qualifying disability) have not had a pathway to Medicaid eligibility except in states choosing to expand access through an §1115 demonstration waiver. Today, a state may choose to cover all low-income adults under its Medicaid state plan.

Define Covered Benefits

Mandatory Medicaid services include hospital, physician, nursing facility, home health services, family planning services, and others. States are also required to provide Early Periodic Screening, Diagnostic and Treatment (EPSDT) services to children (defined to include persons under age 21), which includes periodic screening, appropriate immunizations, vision, dental and hearing services, and any other additional health services that could be covered as an optional Medicaid service.

Once a state meets minimum federal requirements for covered benefits, it has a number of options for designing covered benefits to meet the needs of its beneficiaries. The range of services extends from those commonly covered under traditional commercial products (*e.g.*, physical therapy, occupational therapy, speech therapy, podiatry) to an array of non-traditional services designed to accommodate the needs of the vulnerable populations covered under Medicaid, including case management, community mental health services, and home and community-based services for older adults and persons with disabilities. In addition, unlike private insurers, the Medicaid program is responsible for providing transportation services when those services are necessary to ensure that beneficiaries have access to non-emergency medical services.

States may determine the amount, duration and scope of covered benefits, as long as the service is sufficient to achieve its purpose.[17] In general, the amount, duration and scope of services available to the categorically eligible must be comparable for all within that group. States may condition access to services on a beneficiary's medical need for the service.[18]

The Deficit Reduction Act of 2005 (DRA) gave states a new option to provide a benchmark or benchmark-equivalent benefit package to some groups. States also have the option to provide premium assistance to subsidize the cost of purchasing employer-sponsored coverage. Premium assistance programs must meet certain requirements including providing wraparound coverage to ensure enrollees can still access full Medicaid benefits and cost sharing protections. With exemptions for certain populations and services, states may also impose limited cost-sharing on beneficiaries in the form of co-payments, premiums or deductibles. The establishment of a Medicaid benchmark package for newly-eligible adults based on Essential Health Benefits provides states additional flexibility for coverage for this population, and gives states additional policy design responsibility with respect to their Medicaid programs.

Define Provider Qualifications and Payments

States are responsible for defining provider qualifications and payment. How provider qualifications are defined depends on state licensing laws and the permitted scope of practice for providers. When setting provider qualifications, states have to make trade-offs between the quality and expertise of the provider and the availability of that type of provider in the state. Provider participation in the Medicaid program is limited to those providers who accept Medicaid payment as payment in full.[19]

Payment must be "consistent with efficiency, economy, and quality of care and…sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[20] CMS has proposed rules governing public involvement in the rate reduction process and a framework states may use for assessing the impact of a rate reduction on access.[21] CMS has not proposed rules addressing the other statutory payment requirements of "efficiency, economy, and quality of care."

How payment is structured can influence provider incentives and their accountability for performance and cost. For example, fee for service payment may incent providers to provide more services, but not necessarily higher quality services. Payment might be capitated or partially capitated, holding the provider accountable for providing all necessary services for a particular episode of care or a particular time period.

States must make timely payment to providers. At least 90 percent of "clean" claims, *i.e.*, claims that can be processed without obtaining any additional information from the provider or a third party, must be paid within 30 days of receipt, and at least 99 percent within 90 days.[22] To prevent erroneous payment the state must administer a Medicaid quality control claims processing system.[23]

Design Delivery Systems

A delivery system is built on a foundation of an adequate supply of qualified service providers that forms a continuum of care comprising primary care, specialty and hospital care and restorative care, as well as long term services and supports (LTSS).

Although traditional fee-for-service continues to serve as a common delivery system model, predominantly state Medicaid programs organize their health care delivery systems as some variation of primary care case management (PCCM) or capitated managed care, using payment and accountability to shape how providers interact with one another.[24] Primary care case management allows the Medicaid program to contract directly with a network of primary care providers, or with other organizations, to coordinate services. In a capitated model, states contract with managed care entities (MCEs) to provide Medicaid services.

A state can play a major role in shaping the delivery system for some services, particularly those specialized services designed specifically for specialized Medicaid populations. For example, as states have worked to avoid unnecessary institutional services for persons with disabilities, they have often had to help develop provider capacity to offer home and community-based alternative services. State policy can shape both the entry point for accessing LTSS services as well as who delivers those services and how. In many cases, these policies are not shaped by the Medicaid program alone but require partnerships and the financial participation of sister agencies, as well as federal and local governments.

Program Operations

FEDERAL ROLE

Ensures Proper and Efficient Administration of the Program

CMS may only provide federal financial participation for administration of the Medicaid program if the state's costs are necessary for the proper and efficient administration of the program.[25] To meet these requirements, CMS must oversee all aspects of the Medicaid program. For example, CMS regional offices review all managed care contracts using a contract checklist reflecting the federal program requirements. A similar checklist is used to review state capitation rate setting. CMS also reviews and approves Advanced Planning Documents (APD) when a state wishes to obtain federal financial participation in the cost of acquiring automated data processing equipment and services.[26] The federal government also conducts periodic onsite reviews to assure that the system is used for purposes consistent with the proper and efficient administration of the programs.

CMS ensures that the federal government pays appropriate matching payments for state Medicaid expenditures. The federal government's share of expenditures for services, or the federal medical assistance percentage (FMAP), varies by state and is calculated based on the state's per capita income as a percent of national per capita income.[27] The FMAP can also vary for different services and different population groups (most administrative expenses are matched at a 50 percent FMAP). The state must submit an accounting of actual expenditures (Form CMS–64) within 30 days of the end of each quarter.[28] Each quarter the federal government grants the state a "line of credit" to cover the federal share of expenditures for services, training and administration for the ensuing quarter.[29]

CMS is responsible for reviewing state and local administration of the Medicaid program by analyzing state policies and procedures, conducting on-site review of selected aspects of program administration, and reviewing individual case records.[30] CMS may withhold FFP upon a finding that the state plan no longer complies with state plan requirements defined under §1902 of the Social Security Act, or a finding that the administration of the plan fails to substantially comply with any of the provisions of §1902.[31]

STATE ROLE

Determine Eligibility

Federal regulations governing the eligibility process focus on ensuring that applicants and beneficiaries have the opportunity to apply for Medicaid, and streamlining the process for doing so. With enactment of the ACA, states are also required to coordinate the Medicaid and CHIP eligibility and enrollment processes with that of the Health Insurance Marketplace (hereafter, the "Marketplace"). Once eligibility is determined, the state must furnish Medicaid promptly, without any delay caused by the state's administrative procedures.[32]

Effective January 2014, the application for Medicaid must be a single application form integrating eligibility requirements for all insurance affordability programs, including the Marketplace; states must accept applications submitted through the state's centralized website, by telephone, by mail, in person or through other commonly available electronic means.[33] The Affordable Care Act has standardized the methodology for determining financial eligibility across states for most Medicaid eligibility groups, effective 2014, using the tax code concept of Modified Adjusted Gross Income (MAGI) as the definition of income. This new methodology aligns Medicaid and CHIP eligibility with eligibility criteria to be used for premium subsidies provided through the Marketplace.

In general, states may take no more than 45 days to process applications, except that a state may take 90 days to process applications for persons who apply for Medicaid on the basis of a disability.[34] Effective 2014, states must establish timeliness and performance standards for determining Medicaid eligibility or potential eligibility for other insurance affordability programs "promptly and without undue delay."[35]

For persons applying for Long Term Services and Supports based on their need for an institutional level of care, the eligibility determination process also involves a clinical or functional assessment.[36]

Implement Beneficiary Protections and Safeguards

Federal law grants Medicaid beneficiaries certain protections and rights. Most significantly, like other entitlement programs, Medicaid confers on individuals meeting a state's eligibility criteria a right to Medicaid coverage. Medicaid applicants must be provided information about the eligibility requirements, available Medicaid services and the rights and responsibilities of beneficiaries.[37] This information must be available in paper form and orally. Effective

January 2014, states are also required to make sure this information is accessible to persons with limited English proficiency and persons with disabilities,[38] and provide it in electronic form accessible through a centralized state-supported website that provides information about Medicaid, CHIP, the Marketplace, and other insurance affordability options in the state.[39] Beneficiaries may obtain services from any qualified provider willing to furnish Medicaid services to that beneficiary.[40] Individual applicants or beneficiaries may appeal eligibility decisions and decisions about covered services made by states or plans and providers may appeal decisions regarding payment.

Manage Utilization

States must implement a statewide program for controlling utilization of Medicaid services and address specific utilization controls for institutional services and outpatient drug use. Failure to comply with these requirements may result in penalties. A Medicaid program can contract with a Quality Improvement Organization (QIO) to provide utilization review functions.[41] The statewide utilization and control program must be able to safeguard against unnecessary and inappropriate use of Medicaid services and against excessive payment; assess the quality of services; and provide for the control of utilization as required under federal law.[42]

Claim Federal Financial Participation (FFP)

To claim federal financial participation, states must submit budget and expenditure reports. States are also responsible for collecting and reporting information necessary for effective program administration and ensuring accountability. States are responsible for submitting all reports required by CMS.[43] In addition, states are responsible for maintaining records on beneficiaries and statistical, fiscal and other records necessary for reporting.[44]

Program Integrity

Congress has assigned responsibility for combating provider waste, fraud and abuse to both the federal government and states.

FEDERALROLE

Within HHS, CMS and the Office of Inspector General (OIG), share responsibility for Medicaid program integrity. CMS is responsible for monitoring the state's quality control programs for minimizing erroneous payments, including the Medicaid quality control claims processing system and Medicaid eligibility quality control program.[45] CMS may disallow a percentage of FFP for states having an error rate exceeding three percent.[46] CMS also conducts a Payment Error Rate Measurement (PERM) once every three years, identifying claims errors relating to insufficient documentation, erroneous coding, lack of medical necessity, data processing, and other types of errors, and eligibility errors relating to improper eligibility determinations, denials or terminations and improper managed care enrollment.[47]

The Office of Inspector General (OIG) is responsible for periodically auditing state operations to determine whether the program is being operated in a cost-efficient manner and funds are being properly expended for the purposes for which they were appropriated.[48] For example, OIG reviews states' reimbursement methods for home and community-based services to ensure that Medicaid funds do not pay for unallowable room and board costs. OIG also examines state use of provider taxes to generate federal funding, how states allocate administrative costs, states' quarterly expenditure reporting and other state policies impacting the federal share of Medicaid expenditures.[49]

In addition to minimizing errors, CMS (along with the states) is responsible for preventing, detecting, and reducing provider fraud, waste and abuse. The Deficit Reduction Act established the Medicaid Integrity Program. Within CMS the Medicaid Integrity Group (MIG) is responsible for contracting with provider auditors to review and audit providers and furnish provider education; identifying fraud trends through data analysis and other activities; and reviewing state program integrity operations and providing training and other support. The MIG conducts triennial program integrity reviews, examining state provider enrollment, provider disclosures, program integrity, managed care and the state's relationship to the Medicaid Fraud Control Unit (MFCU). In addition, the MIG is responsible for developing and updating a five-year comprehensive Medicaid integrity plan and reporting annually to Congress on the effectiveness of program integrity spending. The federal government also provides enhanced match to states for their Program Integrity activities.

The OIG also monitors Medicaid expenditures to identify provider waste, fraud and abuse. For example, OIG will review Medicaid expenditures for home and community-based services to ensure Medicare and Medicaid have not both paid for the same services. Recently OIG has targeted billing patterns for pediatric dental care to ensure that dentists' claims are appropriate.[50] In fiscal year 2012, OIG excluded 3,131 individuals and entities from participating as Medicaid providers or suppliers, whether because of crimes relating to Medicaid, Medicare or other health programs; for patient abuse or neglect; or because of licensure revocations.[51]

STATE ROLE

States are responsible for preventing fraud, abuse, and mismanagement in their Medicaid program and for ensuring that federal and state funds are spent appropriately. Federal regulations define minimum state Medicaid program integrity requirements and include a state Medicaid fraud detection and investigation program; provider disclosure requirements; provider screening and enrollment requirements.

The state Medicaid fraud detection and investigation program must include methods and criteria for identifying and investigating fraud. The state is obligated to submit data to CMS on the number of complaints it receives, and details on all complaints that merit an investigation, including the disposition of the case.[52] A state is required to suspend Medicaid payment to a provider after it determines that there is a credible allegation of fraud, unless it has good cause for not doing so.[53]

Federal regulations identify a range of persons or entities that are subject to Medicaid disclosure requirements, including Medicaid providers, their fiscal agents, and certain other providers.[54] To ensure program integrity, states must enroll and screen all ordering physicians and other professionals providing Medicaid services. States must enter into contracts with eligible Medicaid Recovery Audit Contractors (RACs) to identify overpayment and underpayment to providers and recoup overpayment for the state.[55]

Quality and Performance Measurement and Management

The federal government has responsibility for collecting information about Medicaid program performance as well as promoting standard measures for quality and performance. States also have a set of quality management responsibilities, focusing on monitoring and assuring quality of services.

FEDERALROLE

In an effort to better ensure the efficiency and effectiveness of the Medicaid program, CMS has launched several initiatives to improve performance measurement, data collection and reporting, and transparency. CMS is developing a unified information and reporting system to collect data to facilitate program oversight and quality monitoring. This system comprises two primary components. First, when fully implemented, the Medicaid and CHIP Program (MACPro) system will serve as the single repository for state plans, state plan amendments, waiver applications and other key programmatic information, and the system of record for all state Medicaid and CHIP actions. Eventually, MACPRo will contain program and administrative data on state operations, performance, quality and program characteristics.

CMS is also developing the Transformed Medicaid Statistical Information System (TMSIS), which is an expanded and streamlined version of Medical Statistical Information System (MSIS), the claims-based system that serves as the primary data source for managing the Medicaid and CHIP programs. Through the MSIS, states are required to submit quarterly eligibility, enrollment, program, utilization and expenditure data on the Medicaid and CHIP programs. States also submit encounter data through MSIS, although the quality of encounter data varies significantly across states.[56] Because managed care is playing a more significant role in Medicaid, CMS is increasing its efforts to improve the quality of encounter data.[57] MSIS is used to develop analytic extract files for national and state-level analysis of Medicaid beneficiaries and expenditures.

In January 2013, CMS issued a request for information, seeking public input in the development of an initial set of business process performance indicators, with a focus on two primary domains: individual (applicants and beneficiaries) experience with eligibility and enrollment and provider experience with enrollment and payment.[58] CMS would like to use the measures of individual experience to assess the success of integrating eligibility and enrollment across Medicaid, CHIP and the Marketplace. Provider measures will be used to assess the timeliness of provider enrollment, and the intake, adjudication and payment of claims.

To support better quality measurement for Medicaid services, both CHIPRA and the ACA established major new quality measurement initiatives for children and adults. Under CHIPRA, HHS was required to publish a core set of children's health care quality measures for voluntary use by states. CMS has developed the CHIP Annual Reporting Template System (CARTS) for reporting the children's quality measures to CMS. Although participation is voluntary, 48 states and the District of Columbia reported one or more of the initial core set in (FFY) 2011.[59]

Pursuant to the requirements of the Affordable Care Act, HHS has developed and published an initial core set of adult health care quality measures for Medicaid-eligible adults, for voluntary use by states. At the end of 2012, CMS also launched the Adult Medicaid Quality grant program which provides funding to 26 states to test and evaluate methods for collecting and reporting this initial core set of measures; to build staff capacity for reporting, analyzing and using quality data; and for conducting at least two quality improvement activities.

While these quality measurement programs are voluntary, they provide states with a valuable opportunity to adopt these core measures while continuing to tailor their quality management programs to local needs. Having standard measures across states also offer states an opportunity to compare their performance against other states, to identify what they are doing well and where they could improve.

Pursuant to the ACA, CMS has also promulgated regulations governing Provider Preventable Conditions (PPCs) that prohibits federal expenditures for services related to health care-acquired conditions (HCACs). These rules apply to inpatient hospital settings and use a modified version of the HCACs list used for Medicare as the minimum set of conditions that states must identify for non-payment.

STATE ROLE

States have broad authority and flexibility to ensure and monitor quality. States are responsible for establishing and maintaining standards for entities that provide care to Medicaid beneficiaries.

States contracting with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) (collectively referred to as "managed care entities" or "MCEs") must have a quality assessment and performance improvement strategy that holds the MCE to the state's standards. Federal regulations set minimum requirements for the state's standards including standards relating access to services, coordination and continuity of care, practice guidelines, the MCE's quality assessment and quality improvement guidelines and other elements. States contracting with MCOs or PIHPs are required to conduct an external quality review (EQR) of the MCE. The external quality review organization (EQRO) is responsible for validating the MCE's performance improvement projects (PIPs) and performance measures, and reviewing the MCE's compliance with the state's standards for access to care, structure and operations, and quality measurement and improvement. A state may also ask the EQRO to validate encounter data, administer or validate consumer or provider quality surveys, calculate its own performance measures, and conduct its own PIPs or focused quality studies.

States are also responsible for the quality of home and community-based services administered under a §1915(c) waiver. Quality management requirements emphasize measurement, sampling, and the continuous quality improvement (discovery, remediation and system improvement).

States are responsible for inspecting intermediate care facilities and institutions for mental disease to determine that services are adequate to meet a beneficiary's health, rehabilitative and social needs.[60]

Medicaid is Evolving and Faces a Set of New Opportunities and Challenges.

Medicaid is dynamic, and is evolving more rapidly now than at any time since its inception nearly fifty years ago. States and the federal government are trying new approaches designed to better manage costs, increase value to consumers and improve the health of populations. Bending the cost curve, both to ensure the best health care value for the dollar and to manage fiscal pressure, is a shared central state and federal goal, and stronger efforts at collecting and reporting quality of care and other program performance data support that goal.

At the same time, with the implementation of the Affordable Care Act, states are establishing new coverage options for their residents through Medicaid and the Marketplace. States are working with CMS to redesign the policy, processes, and systems that determine eligibility for most of their populations while ensuring that these new policies and systems coordinate with Marketplace coverage and coverage for other health programs like CHIP, and

maintaining existing eligibility systems for older adults and persons with disabilities. Cross program coordination, with both new entities like the Marketplace and established human and social service programs, is key to ensuring that eligible people enroll and that delivery system reform and population health efforts are successful.

Like other health insurers, in the past Medicaid operated as a relatively passive purchaser, with a focus on paying provider claims and the other routine administrative functions of an insurer. However, as Medicaid has matured and evolved, it, like most health insurers in the U.S., has shifted toward a more active role as purchaser, moving to managed care and establishing performance and outcome-based goals in order to maximize the value of health care purchased for the Medicaid dollar.

The changing role of Medicaid means a change in the administrative tasks and functions of Medicaid programs, as well as the range of needed expertise and skills. This section reviews how Medicaid is evolving and its impact on administrative functions.

Streamlining Eligibility Policies and Processes

With implementation of the Affordable Care Act, states are also responsible for ensuring that eligibility for Medicaid and CHIP coordinates with eligibility for coverage under the Marketplace.[61] The transition to the new eligibility systems creates significant administrative challenges for states given their magnitude and the very tight timeframes for completing the transition. However, states also have new opportunities to modernize out-dated eligibility systems, coordinate eligibility across programs, and access additional federal dollars to support these efforts.

Under the ACA, states must participate in a single "no wrong door" eligibility and enrollment process that enrolls individuals in the program they are eligible for regardless of the program they applied for. States must use the federal government's single, streamlined application or an alternative approved by CMS.[62] States may choose how closely they would like to coordinate eligibility determinations with the Marketplace: they can enter into agreements with the Marketplace to have it determine Medicaid eligibility or allow the Marketplace to assess potential eligibility and refer to the Medicaid program for a final determination. Individuals applying for coverage must be evaluated for Medicaid, CHIP, and Marketplace eligibility; state agencies may enter into an agreement with the Marketplace to conduct eligibility determinations for premium subsidy on the Marketplace's behalf.[63]

The eligibility determination process will interface with a federal data services hub developed by HHS to verify citizenship, immigration status, and income and other data obtained from other federal agencies.[64]

Until 2015, CMS has offered states a 90 percent match rate for the design, development and installation or enhancement of Medicaid eligibility determination systems that meet standards that support seamless coordination with the Marketplace.[65] These systems qualify for a 75 percent matching rate for their maintenance operations. States may also qualify for an enhanced 75 percent match rate for certain maintenance and operation functions of state Medicaid Management Information Systems that relate to eligibility determinations, if the MMIS meets the same standards supporting seamlessness and coordination that pertain to eligibility systems.[66]

Once the transition to new rules and systems is completed, it is anticipated that state administration of Medicaid eligibility will be simpler, at least for the majority of beneficiaries whose eligibility is determined based on MAGI. However, the MAGI methodology does not apply to persons qualifying for Medicaid based on being 65 or older, blindness or disability. States will continue to determine eligibility for these groups using current income and resource eligibility standards.

The move to the new Medicaid and CHIP eligibility rules entails significant change for eligibility workers. They must learn the new rules and reengineered processes that support ensuring that eligible people get enrolled in health coverage. Many eligibility workers will also need new expertise in Marketplace coverage to support applicants' ability to navigate the Medicaid and Marketplace eligibility process.

Maximizing Efficiency across Medicaid, Marketplaces and CHIP

As states determine how best to coordinate their Medicaid and CHIP programs with the qualified health plans (QHPs) accessed through the Marketplace, they are addressing some of the challenges of coordinating coverage across affordable insurance programs. Medicaid eligibility fluctuates with changes in income and circumstance, some people who qualify for Medicaid today will not be eligible tomorrow. Other options to coordinate coverage include development of a Basic Health Plan to provide coverage to people with incomes between 139 and 200 percent of the FPL who would otherwise be eligible to purchase health coverage through the Marketplace. Offering a BHP could improve continuity of coverage for people whose income fluctuates above and below Medicaid levels but also raises concerns about potential added administrative responsibilities for states. (Implementation of the BHP has been delayed.[67]) CMS has also expressed its willingness to consider a limited number of proposals to offer premium assistance for the purchase of coverage under a qualified health plan in the Marketplace.[68] In addition, CMS has offered other options to minimize "churning" between Medicaid and insurance accessed through the Marketplace, through 12-month continuous eligibility for parents and other adults and express lane eligibility.[69]

States can also improve coordination across affordable health insurance programs by negotiating with plans to participate in both Medicaid and the new Marketplace so that a change in program eligibility does not have to mean a change in health plan (and a possible disruption in care if the beneficiary's providers do not participate in the new plan's provider network). When program eligibility does change, states need administrative capacity and systems to ensure that the transition occurs smoothly for the beneficiary, providers, the plans, and program administrators.

Delivery System and Payment Reform

Delivery system and payment reforms are at the heart of efforts to better manage costs, increase value to consumers, and improve quality and overall health outcomes. These efforts focus on the use of cost-effective preventive and early intervention services that reduce the need for high cost treatment and provide comprehensive, coordinated care to persons with complex needs who are at high risk for poor health outcomes.

Traditional fee-for-service payment for health care rewards providers for providing more, not better care. The cost of providing care management often goes unrecognized in a pure fee-for-service system, meaning that many with the highest level of need receive fragmented, uncoordinated and unnecessarily expensive care across multiple providers.

The most medically and socially vulnerable Medicaid beneficiaries are often unable to access needed services or comply with care plans because social barriers, such as a lack of transportation, housing, or good nutrition, continue to stand in the way.[70]

A strong delivery system depends on coordination and collaboration across providers, and the systems and supports that enable and incent the use of evidence-based practice, analytic capacity to identify the best allocation of resources across a patient population, and information sharing among providers. It also depends on a more holistic, "person centered" view of beneficiary needs that addresses barriers to care and other factors that impede the cost-effective delivery of care. Other efforts focus on coordinating and integrating physical and mental health care, acute and long-term support services through managed care or other care coordination strategies. States are increasingly interested in using managed care to provide LTSS to older adults and persons with disabilities. A number of states are also participating in demonstrations to integrate Medicare and Medicaid services for persons who are eligible for both programs, or are using other mechanisms to better coordinate the care provided to beneficiaries under Medicare and Medicaid. To address the many challenges of coordinating Medicare and Medicaid services, state Medicaid agencies need staff who are knowledgeable about Medicare policies, processes, and systems.

Like other health care purchasers, state Medicaid programs are becoming active purchasers to get better value for the Medicaid dollar. While many states have pursued managed care, increasingly states are focusing on strengthening care at the "point of delivery" – in the primary care setting and across care settings. States are using a number of payment strategies to promote improved coordination and high quality care. Some states are combining fee-for-service payment with other components, including a per member per month fee to pay for the cost of managing care, incentive payments, or a shared savings payment. Integrated delivery systems may be able to accept payments based on risk or partial risk.

States have used a variety of mechanisms to finance delivery system reform. Through the Center for Medicare and Medicaid Innovation (CMMI), 33 states are participating in 55 competitive grant-funded initiatives. Several of these initiatives recognize that Medicaid is only one of several major health care purchasers; its influence over a delivery system is strengthened when it partners with other payers. Some state Medicaid programs are participating in multi-payer collaboratives focused on realigning primary care practice.[71]

Becoming an active purchaser requires highly skilled staff with the analytic, financial and clinical expertise needed to negotiate and manage contracts, implement sophisticated payment structures, measure and monitor quality and performance, develop the IT systems, and train and educate providers to move from more traditional payments systems. State decisions about how to set and manage capitated payments have important implications for Medicaid oversight. Some states choose to contract with actuarial firms while others have opted to employ actuaries on staff. These decisions may depend on the state's level of experience with capitated models, and the state's ability to attract and retain actuarial staff in compliance with state hiring constraints. In house capacity gives a state a level of control it might not have with a vendor, while a large firm may provide a range of expertise a state might need only on a short term basis.

Rebalancing Long Term Services and Supports

State Medicaid programs are challenged to find the most integrated and cost-effective means of serving older adults and persons with disabilities. Long term services and supports are designed to serve the needs of persons with a continuing need for services, including older adults and persons with disabilities. For many decades, persons with disabilities were served primarily in institutional settings but the enactment of the Americans with Disabilities Act in 1990 and the Supreme Court decision in its *Olmstead v. L.C.* in 1999 that said that public entities must provide persons with disabilities with home and community-based services when appropriate helped to promote more community-based care. The Deficit Reduction Act of 2005 and the Affordable Care Act significantly expanded the array of options and incentives for states to provide Medicaid-funded HCBS and states continue to expand community based care options and take advantage of these new options. Achieving balance between settings and transitioning from institutional care and community based care requires administrative resources to provide oversight and mange this care.

Designing services and delivery systems to meet the specialized needs of LTSS populations requires specialized expertise. In many states, some LTSS providers are unique to the Medicaid program and have no commercial counterpart. Negotiating payment with these providers requires expertise on the population's service needs and the costs of meeting those needs. In addition, some in the LTSS populations need a wide range of social supports in addition to health care. Many Medicaid agencies access needed expertise through sister agencies and other sources.

Medicaid and Inter-Agency Collaboration

Although not as obvious, Medicaid policy and program administration can impact a wide range of state programs, including the educational system, child welfare programs, income assistance programs, and housing, employment, transportation and the criminal justice system. Medicaid programs may also interface with state departments of insurance in regulating managed care plans and coordinating Medicaid and the ACA marketplaces. Operating the Medicaid program in a silo, without recognizing the short and long term impact of Medicaid policy changes in the broader system, can have unintended consequences. The need for policy coordination is most pronounced in relationship to services for persons needing long term supports and services as well as mental health and substance abuse services.

Inter-agency and cross system collaboration can also improve the delivery of care. A Medicaid agency's ability to meet the needs of some of its most vulnerable beneficiaries depends on collaboration with an array of other state and local entities. For example, some states have found that for children with a high level of need, Medicaid-funded behavioral health services are most effective when coordinated with the child's school and, as applicable, the child welfare system and the criminal justice system. Serious mental illness is often associated with a range of physical health conditions impacting health and life expectancy; integrating physical and behavioral health may require a partnership between the Medicaid program and the state's mental health agency, and medical and behavioral health providers. Increasingly, Medicaid agencies are recognizing the need for staff who understand the relationship between Medicaid policy and the public health system and public health model.

In many states, Medicaid is also a "doorway" through which other state agencies or counties and local governments access federal match to finance services. For example, states have used Medicaid funding to pay for case management services provided to a Medicaid beneficiary by a child protective worker employed by the state. Medicaid is also used to reimburse for certain school-based services provided to Medicaid beneficiaries and

correctional agencies have used Medicaid to fund juvenile justice services. Many states have also used Medicaid to finance an increasing portion of mental health services, developmental disability services, and services for older adults and persons with disabilities.

Although states must designate a "single state agency" accountable to the federal government for administering the Medicaid program, some states delegate some responsibilities to sister agencies at the state level or to a county, regional or municipal government.[72] These other government agencies might be responsible for administering mental health programs, developmental disability programs, or other specialized programs. These split responsibilities can create coordination issues across agencies that serve the Medicaid population. Often these other government agencies contribute the state's share of Medicaid match to cover expenditures for the programs they administer and have their own constituencies and legislative relationships. The triangulated relationship between CMS, the Medicaid program, and the sister agency can create compliance challenges for a state, if the sister agency does not closely align its program administration with Medicaid requirements. Similarly, the triangulated relationship between the Medicaid program, the sister agency, and key stakeholders, such as provider or beneficiary groups, can also impede the ability to coordinate care and achieve programmatic goals and efficiencies. Similarly, the triangulated relationship between the Medicaid program, the sister agency, and key stakeholders, such as provider or beneficiary groups, can also impede the ability to coordinate care and achieve programmatic goals and efficiencies.

States have not found one approach for organizing state agencies to optimize inter-agency collaboration and coordination. About two-thirds of states group their Medicaid with other programs under one large umbrella agency.[73] In some cases, the single state agency sits in the executive office of the umbrella agency. In other cases, the Medicaid agency is on equal footing with the other "sister" programs within the umbrella agency. Other states operate their Medicaid program as its own department, independent of the other agencies; 15 percent of Medicaid directors report directly to the governor in their state.[74] Where the state agencies are all held accountable by a single leader it may be easier to foster coordination across state agencies. In the case of autonomous county governments with their own elected officials, collaboration may not be as easy to achieve.

Performance Management, Quality Measurement and Data Management

Quality measurement and reporting go hand in hand with delivery system and payment reform and underpin program performance measurement and success.

As state Medicaid programs transition to active purchasing they will be challenged to use data more effectively. Part of the challenge will be incorporating quality management and performance management into program operations – using measures to give providers meaningful feedback on their performance, to hold providers, managed care organizations, and the Medicaid program accountable for performance.

Quality and performance management requires clinical and analytic expertise, as well as strong leadership ready to incorporate quality and performance measures into management and operations.

Transparency and Public Accountability

Both formally and informally, the Medicaid program is accountable to a wide range of stakeholders within a state. It is legally accountable to beneficiaries, providers, and sometimes courts, and pragmatically and politically accountable to many others.

Beneficiaries are an important source of information when it comes to policy development and program design, as well as performance and quality management. Beneficiaries can provide information about barriers to access, unmet service needs, fragmented service delivery and other important factors that impact the cost-effectiveness of Medicaid services.

Each single state agency must have a medical care advisory committee to advise the Medicaid director on health and medical care services. The committee comprises physicians, members of consumer groups including Medicaid beneficiaries, and the director of the public welfare department of the public health department, whichever does not head the Medicaid agency.[75] The committee must have an opportunity to participate in policy development and program administration. The state must provide support to the committee including independent technical assistance as needed and financial arrangements as necessary to facilitate beneficiary participation.

States must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.[76] CMS has also issued proposed regulations that describe a voluntary public process for initiating payment rate changes.[77] States are also complying with recent federal guidance around ensuring transparency and meaningful public input into several core state processes, such as establishing payment rates, developing and submitting §1115 demonstrations, and consulting with tribes in areas that concern tribal members and providers.

As a public agency, with responsibility for what is often the largest portion of a state's budget, a Medicaid program is often under pressure to explain its expenditures and budgets to a governor, state legislators and the general public. Competition for access to billions of dollars of Medicaid financing also subjects Medicaid policy choices and purchasing decisions to heightened scrutiny. While "transparency" means different things in different states, many states invest significant resources into publishing reports on program quality and performance on state websites. Many states also regulate the procurement and policymaking process to ensure accountability.

To fulfill their many responsibilities for public engagement a state Medicaid program must have high level staff with the communication skills and judgment necessary to represent the Medicaid program with key constituents and carry their input back to policymaking discussions. Fulfilling transparency requirements requires an investment in staff and resources for collecting information and presenting it in a format accessible to a variety of audiences.

Adequate Administrative Capacity is Key to Realizing the Goal of Running a High Performing Medicaid Program.

A state's ability to make the most of the opportunities currently available to it depends on its ability to effectively and efficiently manage its program. Administrative capacity includes at least three key elements: resources, skills and systems.

Investment in administrative capacity is a shared responsibility across the federal government and states. The federal government's contribution to the state's administrative capacity varies depending on the type of administrative activity. For example, Congress has placed a high priority on detecting and investigating provider fraud and abuse and covers 90 percent of the costs associated with the state's Medicaid fraud control unit's activities relating to investigating and prosecuting provider fraud, abuse and neglect. In contrast, the federal government contributes

50 percent of the costs of the Medicaid agency's administrative functions, functions which, if well-performed, could contribute to preventing fraud, abuse, and neglect. See Appendix 3 for more information about the federal matching rate for different types of state administrative expenditures.

Resources Sufficient to Manage a Large, 21st Century Program

Medicaid covered over 66 million in FY 2010 and in FY 2011 total Medicaid spending excluding administration totaled about $414 billion.[78] Although managing a program of that magnitude requires a high level of administrative capacity, over the past several years state budget cuts have meant reductions in state-level funding and staffing. In many states, the Medicaid administrative budget is particularly vulnerable. The federal government covers 50% of a state Medicaid program's administrative costs. For Medicaid services the matching rate ranges from a 50% minimum to as high as 73%, depending on the state's per capita income. When a state economy is strong a state legislature may be more likely to expand Medicaid, using a dollar of state funds to draw down more federal dollars. In some cases, the incentive might be to expand the program but not necessarily the administrative capacity to manage it. During an economic downturn, when the need for a balanced budget requires significant cuts, the Medicaid program can be an obvious target, as a major portion of the state budget. Often state legislatures will resist cutting services and the administrative budget takes the deepest cut, with the impact of that cut magnified by the reduced federal match: a $1 cut in state dollars results in a $2 cut in the Medicaid agency's administrative budget.

In the midst of the most recent recession, staff furloughs have been a common strategy for managing administrative funding reductions. While these reductions have leveled off in recent years, increased investment in funding and staffing Medicaid agencies has been limited. As a result of budget cuts fewer staff members are available to carry a heavier burden. Timelines for implementing ACA reforms has also increased demands on Medicaid program staff.

Within the level of resources provided, state personnel and contracting requirements can either support or impede the effective deployment of resources. Whether fulfilling its basic responsibilities for administering a Medicaid program or retooling its operations to respond to new demands, a Medicaid agency does not always have the discretion to hire needed staff. In many states, decisions about who to hire and how much to pay them are regulated under civil service codes and other restrictions and subject to scrutiny by state legislators and the public at large. Standard job classifications set common pay rates across state agencies. To protect civil servants, state employees are often protected from termination without cause. Decisions to change job responsibilities in response to a change in business process may be restricted. In some states, contracting for services is not allowed if state employees might be able to provide the services.

Just as Medicaid is not like other health insurers, neither can it be easily compared to other typical state agencies. In most states, Medicaid represents a dominant share of total state budgets and accounts for the second largest share of state general fund spending. The greater responsibility and the greater potential magnitude of errors, suggests that states might have a rationale for differentiating Medicaid salaries from other state agencies. However, intrastate politics can make it difficult for governors and legislatures to justify differential treatment, in spite of the potentially high return on investment.

Restrictions on the procurement process also vary across states. In some states, the procurement process is highly regulated and contracting decisions are subject to review of the governor and other high level officials. In addition, states may not have the flexibility to quickly amend a contract; for major changes a new procurement process may be required. When a state chooses to contract out these functions it still remains accountable for their performance and must ensure that it has capacity for contractor management and oversight.

With these restrictions on hiring and procurement decisions, state Medicaid programs must compete for sophisticated clinical, financial and analytic expertise that can match that of the managed care organizations and providers they are negotiating with yet they can rarely pay what the private sector does. Despite lower salaries, Medicaid programs are able to attract talented and creative staff who value the opportunity to work in an innovative, public service environment, but state personnel system restrictions can reduce the pool of potential applicants as well as the state's ability to retain high quality workers over time. States are also beginning to see the first rounds of baby boomer retirements and challenged to meet the additional requirements of the Affordable Care Act. In some cases, the state will opt to contract out for expertise, but the lack of investment in in-house expertise can limit access and leave that expertise vulnerable to contract renewals and negotiations. However, even when a state contracts out for expertise, the state needs the staff capacity to oversee those contracts and consultants.

A Skill Set that Emphasizes Leadership, Policy Design, Operations, and Analytics.

Possessing the right skills at both the leadership and staff level are essential to achieving a high-performing Medicaid program. At the leadership level, state Medicaid directors establish a strategic vision for the agency, oversee day-to-day operations to support that vision, manage legislative and stakeholder relationships, and ensure accountability. State agency staff develop policy and programs, manage large contracts, oversee operations, budget and finances and ensure quality and performance. To do this successfully, state staff need policy design skills, policy and data analytics, experience in managing personnel and contracts, and skills to ensure effective management and oversight.

The Medicaid director must also be ready to hold staff accountable for their performance, and ready to be held accountable to the federal government, the governor, legislature and greater public. How a leader's time is distributed will depend on the state's political and legal environment. In practice, many Medicaid directors find their time is spent in meetings with internal and external relationships, building relationships, making sure policy is effectively communicated, building staff capacity, making decisions, and "putting out fires."

On the financial side, business managers must be able to project expenditures based on measures of past experience and changes in the environment, including policy changes made by the Medicaid program, policy changes made by another agency, or anticipated changes in enrollment. The budgeting process can be time consuming not only for financial staff; program staff will be called upon to analyze and defend past and projected expenditures and leadership will be doing the same in a much more political environment before the governor, the legislature and others. A Medicaid program may also be called upon to defend actual expenditures when unanticipated increases in enrollment or costs put the Medicaid program over budget. Financial management also includes accountability to CMS for appropriate claims for federal match, requiring a strong understanding of federal and state Medicaid policy.

Policymakers and managers need to understand applicable federal and state law, the needs of the beneficiary population, the capacity and qualifications of the provider population, and the relationship of the Medicaid program to other state agencies, and anticipate the impact of policy changes on Medicaid expenditures, beneficiaries, and providers. Policymakers must also be able to engage internal and external stakeholders in the policy making process, including program design, development and implementation, and understand the impact of policy changes on program operations. Effective rulemaking, which must be done in compliance with state administrative procedural requirements, should also reflect the expertise of both internal and external stakeholders, who can help policymakers avoid the unintended consequences that could result from uninformed policy.

Operational staff must be able to operate beneficiary eligibility and enrollment and provider enrollment and payment in compliance with federal and state law. Well-trained frontline workers are needed, as well as strong supervisors who, in addition to having good supervisory skills also understand state and federal policy and procedures. Personnel who can manage procurement and manage contracts in compliance with state and applicable federal law are also needed. To support operations the Medicaid program must have and support a flexible information systems that can manage beneficiary eligibility and enrollment and provider enrollment, pay claims, and change with changes in policy. Operational staff also must be ready to translate changes in policy into a change in business practice, whether through revisions to procedures, forms, contracts, and information systems, training, communications, or other means. In addition, it is important to have a feedback loop between frontline staff and management to make sure problems are identified quickly.

Analytic personnel, skilled at using data, are needed for measuring and managing program performance and quality. At a minimum, analytic staff should be able to measure and analyze service use and expenditures, to identify gaps in care or avoidable expenditures. Analytic capacity can also be applied to measures of beneficiary experience of care, provider capacity, and program and service quality. To support its management and analytic function a Medicaid program requires a responsive decision support system that can be readily modified to provide timely and relevant data on quality, performance, program integrity and, where applicable, support states' efforts at improved coordination of care.

Leadership within the Medicaid program needs to coordinate and integrate program finance, policy, operations and performance management, to ensure that informed policy is effectively implemented. Having staff with dedicated responsibility for spanning program or administrative boundaries can help staff with responsibility for day-to-day operations identify and act upon necessary linkages.

Systems Developed to Support Performance.

Systems support nearly every day-to-day transaction that Medicaid undertakes, and their performance underpins the efficiency of the program. Systems handle routine transactions quickly and efficiently, freeing staff to focus on more complex tasks. They also gather data and serve as the basis of the data analytics that have become central to measuring and ensuring the performance of each health insurance program and the health care system as a whole.

Conclusion

The Medicaid program, administered jointly by the Federal and state governments, serves 66 million people at a cost of over 400 billion dollars annually, making it the nation's largest public health insurer. The Affordable Care Act further increases the program's reach and supports state-level innovation already underway to improve the program's efficiency and effectiveness and restructure service delivery and payment.

Responsibility for ensuring that states have adequate capacity to manage their Medicaid program resides at both the state and federal level. With the support of the federal government, states are responsible for ensuring the adequacy of their own resources and ensuring the adequacy of their internal processes. Unfortunately, the natural forces of the state budgeting process often work against state investment in a Medicaid program's administrative capacity, at the same time that the complexity of managing a Medicaid program has only increased over time. Inadequate investment in Medicaid administrative capacity could undermine a state's ability to fulfill its responsibilities under federal and state law, as well as its ability to achieve the most from this important program.

Appendices

1. Acronyms and Glossary

ACRONYMS	
ABP	Alternative Benefit Plan
ACA	Affordable Care Act
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentage
GAO	U.S. Government Accountability Office, f.k.a., General Accounting Office
HIPAA	Health Insurance Portability and Accountability Act of 1996.
HHS	U.S. Department of Health and Human Services
MMIS	Medicaid Management Information System
OIG	Office of Inspector General, HHS
OMB	Office of Management and Budget
LTSS	Long Term Services and Supports
KEY TERMS	
Marketplace	the health insurance marketplace, also known as the health insurance exchange, is a federal or state-operated entity through which individuals may purchase health coverage.
Waiver	A waiver is a waiver of Medicaid state plan requirements granted by CMS under its waiver authority granted by Congress. The most commonly used waiver authorities include §1915(b), §1915(c) and §1115.
State Plan	As approved by CMS, a Medicaid state plan is a contract between CMS and the state describing how the state administers its Medicaid program.
State Plan Amendment	A state plan amendment is an amendment to the state plan, as approved by CMS.

2. Medicaid Program Administration: Key Statutory and Regulatory Provisions

STATE ORGANIZATION	STATUTES	REGULATIONS
Establish single state agency	§1902(a)(5)	42 CFR §431.10
Establish state Medicaid unit within state agency	§1902(a)(4)	42 CFR §431.11
Establish medical care advisory committee	§1902(a)(4)	42 CFR §431.12
Specify the agency that determines eligibility	§1902(a)(5)	42 CFR §431.10(c)
Establish methods of personnel administration and training in compliance with federal standards	§1902(a)(4)	42 CFR §432.10 and §432.30-§432.32
Establish separate and distinct Medicaid fraud control unit	§§1903(a)(6), 1903(b)(3), and 1903(q), as amended by Medicare-Medicaid Anti-Fraud and Abuse Amendments (PL 95-142)	42 CFR Part 1007
POLICY AND PROGRAM DEVELOPMENT	**STATUTES**	**REGULATIONS**
Define Medicaid program eligibility	§1902(a)(10)	42 CFR Parts 435 and 436
Define Medicaid covered services	§1905(a), §1915 and §1937	42 CFR Parts 440 and 441
Determine relationship between Medicaid and CHIP	§2103(a)	42 CFR §457.410
Define characteristics of delivery system	§1903, §1905(t), 1915(b), §1932	42 CFR Part 438
Obtain and maintain CMS' approval of state plan and state plan amendments	§1902(a)(4)	42 CFR § 430.10 and §430.12
Obtain and maintain CMS' approval of waivers	§1115(d), §1915(b) and (c)	42 CFR §430.25 and 42 CFR Part 431, Subpart G
BENEFICIARY ENROLLMENT	**STATUTES**	**REGULATIONS**
Establish procedures for conducting outreach to vulnerable populations	§1943(b)(1)(F)	NA
Make accessible program information available	§1943(b)(1)(A) , Civil Rights Act of 1964, §504 of the Rehabilitation Act	42 CFR §435.905
Accept applications	§1902(a)(8)	42 CFR §435.906 – §435.907
Determine beneficiary eligibility timely, verify income and eligibility	§1137, §1902(a)(4), §1902(a)(19), §1902(r)(3) and §1943(b)(3)	42 CFR §435.911 – §435.912 42 CFR §435-940 – §435.960
Coordinate eligibility with CHIP and the Marketplace	§1943 and §2102(b)(3)(B) of the ACA	42 CFR §435.1200
Conduct quality control for eligibility determinations	§1902(a)(4) and §1903(u)	42 CFR §431.810 – §431.822

BENEFICIARY RIGHTS	STATUTES	REGULATIONS
Notify beneficiaries of rights and responsibilities	§1902(a)(4)	42 CFR §435.905
Protect confidentiality of beneficiary's protected information	§1902(a)(7)	42 CFR Part 431, Subpart F
Protect beneficiary's free choice of provider	§1902(23)	42 CFR §431.51
Provide comparable services (amount, duration and scope) within eligibility groups	§1902(10)(B)	42 CFR §440.230
Provide non-emergency medical transportation, as necessary	§1902(a)(4)(A)	42 CFR §431.53
Conduct fair hearings in compliance with federal requirements	§1902(a)(3)	42 CFR Part 431, Subpart E
UTILIZATION MANAGEMENT	**STATUTES**	**REGULATIONS**
Establish and monitor utilization control program	§1902(a)(30)	42 CFR §456.3 – §456.4
Conduct ongoing evaluation and post-payment review for all Medicaid services	§1902(a)(30)	42 CFR §456.21 – §456.23
Implement utilization control requirements for hospital and institutional services	§1903(g), §1902(a)(30), §1902(a)(31)	42 CFR §456.150 – §456.482
Implement utilization control requirements for drug review program	§1903(g)	42 CFR §456.700 – §456.725
PROVIDER ENROLLMENT	**STATUTES**	**REGULATIONS**
Implement provider screening requirements	§1902(a)(39) and §1902(a)(77)	42 CFR §455.400 – §455.470
Implement provider and fiscal agent disclosures requirements	§1124, §1126, and §1902(a)(38)	42 CFR §455.100 – §455.106
Enter into provider agreements	§1902(a)(27)	42 CFR §431.107
PURCHASING AND CONTRACTS	**Statutes**	**Regulations**
Ensure contracts for furnishing Medicaid services, processing or paying Medicaid claims or enhancing Medicaid program administration comply with federal contracting requirements	§1902(a)(4)	42 CFR Part 434
Ensure managed care contracts comply with federal requirements, submit contracts to CMS for review	§1903(m), §1905(t), §1932	42 CFR §438.6
PROVIDER PAYMENT	**STATUTES**	**REGULATIONS**
Define provider payment methodology in compliance with federal requirements	1903(i), §1902(a)(13), §1902(a)(15), §1902(a)(30), §1902(a)(32), §1902(a)(54), and §1913(b)	42 CFR Part 447
Pay claims timely	**§1902(a)(27)**	**42 CFR §447.**
Conduct quality control for claims	§1902(a)(4) and §1903(u)	42 CFR §431.830 – §431.836

MANAGED CARE	STATUTES	REGULATIONS
As applicable establish primary care case management or capitated managed care program in compliance with federal requirements	§1903(m), §1905(t), §1932	42 CFR Part 438
Ensure managed care entities protect enrollee rights and responsibilities	§1932	42 CFR Part 438, Subpart C
Conduct quality assessment and performance improvement	§1932	42 CFR Part 438, Subpart D
Ensure that external quality review is conducted for care organizations and prepaid inpatient health plans	§1932, §1903(a)(3)(C)(ii), and §1902(a)(4)	42 CFR Part 438, Subpart E
Ensure that enrollees have access to a grievance process, appeal process and access to the state's fair hearing process	§1902(a)(3), §1902(a)(4), and §1932(b)(4)	42 CFR Part 438, Subpart H
PROGRAM INTEGRITY	**STATUTES**	**REGULATIONS**
Establish detection and investigation program	§1902(a)(4), §1903(i)(2), and §1909	42 CFR Part 455, subpart A
Conduct independent audit of payments to disproportionate share hospitals (DSH)	§1923(j)(2)	42 CFR Part 455, subpart D
Establish Medicaid Recovery Audit Program	§1902(a)(42)(B)	42 CFR Part 455, subpart F
REPORTING PROGRAM INFORMATION	**STATUTES**	**REGULATIONS**
Comply with CMS reporting requirements	§1902(a)(4)	42 CFR §431.16
Submit quarterly budget estimates to CMS	§1902(a)(4)	42 CFR §430.30(b)
Submit expenditure reports to CMS	§1902(a)(4)	42 CFR §430.30(c)
Submit §1115 waiver reports to CMS	§1115(d)	42 CFR §431.428
QUALITY MANAGEMENT	**STATUTES**	**REGULATIONS**
Implement state program for licensing nursing home administrators	§1903(a)(29) and §1908	42 CFR Part 431, Subpart N
Implement quality assurance program for managed care	§1932(c)(1)	42 CFR Part 438, Subpart D
Ensure that a qualified external review organization performs an annual external quality review of managed care organizations and prepaid inpatient health plans	§1932(c)(2)	42 CFR Part 438, Subpart E
Define methods and standards for assuring quality of services	§1902(a)(22)(D)	42 CFR §440.260
Describe safeguards for protecting health and welfare of beneficiaries receiving HCBS services	§1915(c), §1915(j), §1915(k)	42 CFR §441.303, §441.462, §441.570
Provide minimum protections to beneficiaries using community supported living arrangements	§1930(h)(1)(B)	42 CFR §441.404
Provide quality assurance and risk management plan for self-directed personal assistance services	§1915(j)(5)(E)	42 CFR §441.474 – §441.476
Establish quality assurance system for Community First Choice programs	§1915(k)	42 CFR §441.585

3. Federal Share of Administrative Expenditures

ADMINISTRATIVE COST	FFP	CITE
Administration of family planning services	90%	42 CFR §433.15(b)(2)
Design, development, installation, or enhancement of an eligibility determination system	90%	42 CFR §433.112(c)
Design, development, or installation of mechanized claims processing and information retrieval systems	90%[79]	42 CFR §433.15(b)(3)
Operation of mechanized claims processing and information retrieval systems	75%	42 CFR §433.15(b)(4)
Compensation and training of skilled professional medical personnel and staff directly supporting	75%	42 CFR §433.15(b)(5)
Funds expended for the performance of medical and utilization review by a QIO	75%	42 CFR §433.15(b)(6)
All other activities the Secretary finds necessary for proper and efficient administration of the State plan	50%	42 CFR §433.15(b)(7)
State Medicaid fraud control units	90%	42 CFR §1007.19(a)
Nurse aide training and competency evaluation programs and competency evaluation programs	The lesser of 90% or FMAP plus 25 percentage points	42 CFR §433.15(b)(8)
Preadmission screening and annual resident review (PASARR) activities conducted by the State	75%	42 CFR §433.15(b)(9)
Funds expended for the performance of external quality review or the related activities described in § 438.358 of this chapter when they are performed by an external quality review organization as defined in § 438.320	75%	42 CFR §433.15(b)(10)
Skilled professional medical personnel and directly supporting staff	75%	42 CFR §432.50(b)(1)
Personnel engaged directly in the operation of mechanized claims processing and information retrieval systems	75%	42 CFR §432.50(b)(2)
Personnel engaged in the design, development, or installation of mechanized claims processing and information retrieval systems	50% (training) 90% all other staffing costs	42 CFR §432.50(b)(3)
For personnel administering family planning services and supplies	90%	42 CFR §432.50(b)(5)
For all other staff of the Medicaid agency or other public agencies providing services to the Medicaid agency	50%	42 CFR §432.50(b)(6)
Medical care advisory committee activities	50%	42 CFR §431.12(g)
External quality review and related activities conducted by EQRO or its subcontractors	75%	42 CFR §438.370(a)
External quality review related activities conducted by organization other than EQRO	50%	42 CFR §438.370(b)
Services pending hearing, per court order, retroactive services, etc. related to hearing	FMAP	42 CFR §431.250(b)

Endnotes

[1] Medicaid Enrollment for FY2010, http://www.kff.org/medicaid/state-indicator/total-medicaid-enrollment/ and Medicaid Spending for FY 2011, http://www.kff.org/medicaid/state-indicator/total-medicaid-spending/. Kaiser Family Foundation, State Health Facts.

[2] §1102(a) of the Social Security Act.

[3] CMS has also published a state Medicaid manual which provides informational and procedural materials for state program administration. The manual has not been kept current and cannot be considered authoritative, but can be a useful resource for detail not found elsewhere. Accessed May 13, 2013 at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

[4] 42 CFR §430.14.

[5] States are also allowed to implement capitated managed care programs under state plan and §1115 authority.

[6] §1115A.

[7] Center for Medicare & Medicaid Innovation, *Where Innovation is Happening*, accessed July 9, 2013 at http://innovation.cms.gov/initiatives/map/index.html#model=incentives-for-the-prevention-of-chronic-disease-in-medicaid-demonstration+medicaid-emergency-psychiatric-demonstration+multi-payer-advanced-primary-care-program+state-innovation-models-initiative-model-design-awards+state-innovation-models-initiative-model-pre-testing-awards+state-i-nnovation-models-initiative-model-testing-awards.

[8] National Association of Medicaid Directors, *NAMD'S 1st Annual Medicaid Operations Survey: 2012 Chart Book* (Washington, DC: National Association of Medicaid Directors, 2012); accessed August 7, 2013 at http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_mcdops_chartbook_final_102612.pdf.

[9] 42 CFR §431.10.

[10] 42 CFR §431.11.

[11] 42 CFR §431.10(c).

[12] 42 CFR §435.904(d).

[13] National Association of Medicaid Directors, note 8.

[14] Ibid.

[15] Centers for Medicare & Medicaid Services, *MMIS Fiscal Agent Contract Status Report* (Baltimore, MD: CMS, April 27, 2012); accessed July 6, 2013 at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/MMISFACSR.pdf.

[16] Kaiser Commission on Medicaid and the Uninsured, Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues (Washington DC: Kaiser Family Foundations, April 2011); accessed August 7, 2013 at http://www.kff.org/health-reform/fact-sheet/federal-core-requirements-and-state-options-in/.

[17] 42 CFR §440.230.

[18] 42 CFR §440.230.

[19] 42 CFR §447.15.

[20] 1902(a)(30)(A).

[21] 76 FR 26342 (May 6, 2011).

[22] §1902(a)(37) and 42 CFR §447.45.

[23] 42 CFR §431.830.

[24] The federal government uses the term "managed care" to refer to both primary care case management and capitated managed care. For the purpose of this document, we only refer to capitated managed care as "managed care."

[25] See, *e.g.*, §1903(a)(7) of the Social Security Act.

[26] A planning APD is relatively brief, describing why the project is necessary, a project management plan for the planning process, budget, the allocation of costs across the state and federal governments, and other information. Upon completion of the planning phase, the state must submit an Implementation APD which provides greater detail on the system requirements, and the state's implementation plan.

[27] 42 CFR §433.10(b).

[28] 42 CFR §430.30(c).

[29] 42 CFR §430.30(d).

[30] 42 CFR §430.32.

[31] 42 CFR §430.35(a).

[32] 42 CFR §435.930 and §1902(a)(8). This requirement extends to beneficiaries enrolled in a managed care plan and ensuring that beneficiaries are informed about their choice of plans.

[33] 42 CFR §435.905.

[34] 42 CFR §435.912.

[35] 42 CFR §435.911(c), effective January 1, 2014.

[36] 42 CFR §441.352(c).

[37] 42 CFR §435.905.

[38] 42 CFR §435.908, effective January 1, 2014.

[39] 42 CFR §435.1200(f).

[40] §1902(a)(23) and 42 CFR §431.51(b)(1).

[41] 42 CFR §456.2(b)(2).

[42] 42 CFR §456.3.

[43] 42 CFR §431.16.

[44] 42 CFR §431.17.

[45] 42 CFR §§ 431.810 and 431.830.

[46] 42 CFR §431.865.

[47] Centers for Medicare & Medicaid Services, *Medicaid Improper Payment Findings: FY 2009 – FY 2011 Payment Error Rate Measurement Cycles* (Baltimore, MD: CMS, December 2012); accessed July 6, 2013 at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Downloads/FY-2009-2011-Medicaid-improper-Payment-Findings.pdf.

[48] 42 CFR §430.33(a).

[49] Office of Inspector General, U.S. Department of Health and Human Services, *Office of Inspector General Work Plan, Fiscal Year 2013* (Washington, DC: U.S. Department of Health and Human Services); accessed August 7, 2013 at http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf.

[50] Ibid.

[51] U.S. Department of Health and Human Services and U.S. Department of Justice, *Health Care Fraud and Abuse Control Program: Annual Report for Fiscal Year 2012* (Washington, DC: DHHS and DOJ, February 2013); accessed August 7, 2013 at http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf.

[52] 42 CFR §455.17.

[53] 42 CFR §455.23.

[54] 42 CFR §455.104.

[55] 42 CFR §455.506(a).

[56] Byrd, V.H. and Verdier, J., *Collecting, Using, and Reporting Medicaid Encounter Data: A Primer for States* (Washington, DC: Mathematica Policy Research, October 19, 2011).

[57] Ibid.

[58] Centers for Medicare & Medicaid Services, *Request for Information: Performance Indicators for Medicaid and Children's Health Insurance Program (CHIP) Business Functions: Solicitation of Public Input* (Baltimore, MD: CMS, undated); accessed August 7, 2013 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/RFI-Performance-Indicators-1-24-13.pdf.

[59] Centers for Medicare & Medicaid Services, *Letter to State Health Officials and Medicaid Directors in re 2013 Children's Core Set of Health Care Quality Measures* (Baltimore, MD: CMS, SHO # 13-002, January 24, 2013); accessed August 7, 2013 at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf.

[60] 42 CFR §456.609.

[61] 42 CFR §433.112(b)(16).

[62] 42 CFR §435.907, effective January 1, 2014.

[63] 42 CRF §435.1200.

[64] Center for Medicaid and CHIP Services, *CMCS Informational Bulletin in re MAGI-Based Eligibility Verification Plans* (Baltimore, MD: CMS, February 21, 2013); accessed August 7, 2013 at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-02-21-13.pdf.

[65] Centers for Medicare & Medicaid Services, *Recent Developments in Medicaid* (Baltimore, MD: CMS, CMCS Informational Bulletin, April 14, 2011); accessed August 7, 2013 at http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/Info-Bulletin-4-14-11.pdf.

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[71] Centers for Medicare & Medicaid Services, Fact Sheet: Multi-payer Advanced Primary Care Practice (MAPCP) (Baltimore, MD: CMS, April 5, 2012); accessed August 7, 2013 at http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/mapcpdemo_Factsheet.pdf.

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[73] Ibid.

[74] Ibid.

[75] 42 CFR §431.12.

[76] 42 CFR §447.205.

[77] 76 Fed. Reg. 26342 (May 6, 2011).

[78] Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/state-indicator/total-medicaid-spending-fy2010/ and http://www.kff.org/medicaid/state-indicator/total-medicaid-enrollment-fy2009/

[79] This enhanced match is time limited from 4.19.11 through 12.31.15.

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