CMS Seven Standards and Conditions for Enhanced Funding

On April 11, 2011, the Centers for Medicare and Medicaid Services (CMS) issued new standards and conditions that must be met by the states in order for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for enhanced Federal Financial Participation (FFP) funding. This regulation is meant to build on the work CMS, states and private industry have done over the last six years under the Medicaid Information Technology Architecture (MITA) initiative. The MITA initiative produced an architecture framework—business, technical, and information—along with a business maturity model for process improvement, that guides the planning of technology and infrastructure build-out to meet the changing business needs of Medicaid programs.

Seven Standards and Conditions:

1. **Modularity**: This condition requires the use of a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces (API); the separation of business rules from core programming; and the availability of business rules in both human and machine-readable formats. This is in order to ensure that states can more easily change and maintain systems, as well as integrate and interoperate with a clinical and administrative network designed to deliver person-centric services and benefits.

2. **MITA Condition**: This condition requires states to align to and advance increasingly in MITA maturity for business, architecture, and data. States are to complete and continue to make measurable progress in implementing their MITA Maturity Model roadmaps, MITA Self-Assessments, and Concept of Operations (COO) and Business Process Models (BPM).

3. **Industry Standards Condition**: States must ensure alignment with, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy and transaction standards; and accessibility standards.

4. **Leverage Condition**: State solutions should promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states. This condition encourages states to identify any components and solutions that are being developed with the participation of or contribution by other states; solutions that have high applicability for other reuse by other states; and service-based and cloud-first strategy for system development.

5. **Business Results Condition**: Systems should support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public. A system should employ effective and efficient

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business process, producing and communicating the intended operational results with a high degree of reliability and accuracy.

6. **Reporting Condition**: Solutions should produce transaction data, reports, and performance information that contribute to program evaluations, continuous improvement in business operations, and transparency and accountability.

7. **Interoperability Condition**: Systems must ensure seamless coordination and integration with the Exchange (whether run by the state or federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.