



## MITA and Medicaid Transformation<sup>1</sup>

Medicaid is one of the world's largest insurance systems, providing coverage to 55 million poor and elderly Americans. It is also one of the world's largest health information systems. Yet since its inception in 1965 as one of Lyndon Johnson's Great Society programs, claims payment has been its dominant business. As a health information system, containing a wealth of encounter data that could be invaluable to researchers, physicians, and patients, it has barely begun to tell its tale.

Medicaid is best viewed as a joint venture between the states and the Federal government. Funded largely by the Federal government, which sets essential ground rules, and administered locally by the states, it is a sprawling collaborative enterprise with many masters, stakeholders and customers – not the least of which is every state legislature, and the United States Congress.

The principal Federal investment has always been in claims processing – and for that, it has turned to computers. Those systems are referred to, collectively, as the Medicaid Management Information System, or MMIS.

To spur development and migration, the legislation that established the MMIS in 1972 provided for a 90/10 split between the Federal government and the states to design, develop and install these systems. There is thus a huge financial driver for the states to conduct their business on MMIS, and all do. Once built, the matching rate falls to 75/25 for operating the systems. The Federal government thereafter shares Medicaid's administrative costs evenly with the states.

The legislation and regulations do not, per se, define MMIS: that is left up to the Federal agency responsible for it, originally the Health Care Financing Administration (HCFA), and now the Centers for Medicare and Medicaid Services, or CMS. While the MMIS legislative charter refers to MMIS as a "claims processing and information retrieval system", for thirty years or more the principal focus has been on the former, and not the latter. HCFA, and later CMS, defined MMIS tightly around claims processing: everything associated with what a state must do in order to process a claim from a

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physician, a laboratory, hospital or other provider to get paid for a service is clearly and completely described. It became the touchstone, in effect, for defining the outer limits of the MMIS.

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The states have often been characterized as laboratories of experimentation, and the MMIS experience has been little different. MMIS, in fact, has been a dynamic enterprise, changing with the times as technologies like decision support systems and data warehouses were being built in the 1980s. The states have customized MMIS steadily over the past forty years with innovations focused on perfecting the claims processing capability, and the diagnoses and procedure codes that system administrators needed in order to pay claims accurately and timely.

These developments responded to a patchwork of incentives. Somewhat like weeds sprouting in a vacant lot wherever there is sun and water, the MMIS grew alongside other systems towards the nurturing flow of Federal financial incentives, creating a patchwork of systems – many dealing with the same recipients, few being able to cross-walk data on incidents or health. Whether by policy, design, or happenstance, these related but different systems, serving the same Medicaid population but for different purposes, have grown up unable to exchange data easily.

The boundaries between organizations, and states, exemplified in their powerful but separate systems have often frustrated policy makers. It was not uncommon, for example, for Medicaid directors to be called before state legislative committees to explain programs about which they could provide little information, because their IT systems -- their data sources –could not produce the reports.

The truth was that state Medicaid directors were seldom if at all held accountable for beneficiaries' health. They were, however, inevitably called to account for overall administrative costs. Nor, for that matter, were there reliable bridges built upon the MMIS that could expose data from the Medicaid community to the public health community and provide data and insights on outcomes for health.

“Some migrant workers move from state to state along the Eastern Seaboard, from Florida to Georgia, through the Carolinas and on to upstate New York over the course of a season, following the harvests,” offered Rick Friedman. Friedman is CMS’ Director of the Division of State Systems, the organization most directly responsible for the definition and funding of the MMIS. A legislator might ask, for example, the sum total of services a particular claimant received in all these states. “The Medicaid director is sitting there on the hot seat with blinders on from his IT system and he or she cannot possibly answer that question, because Florida’s system can’t talk to Georgia’s, South Carolina’s can’t talk to New York’s, etc. about the same person.”

The problem was just as keenly felt *within* a state as among them, as the lack of interoperability between a state's own systems hampered policy makers. Organizations which each touched a beneficiary – Medicaid and the Department of Public Health, for example – could run non-interoperable systems and have little idea whether they were paying for the same service multiple times or what the health outcomes for the beneficiary might be. “The whole picture from a patient's perspective -- as opposed to a payer's or organizational silo's -- just never got put *together*,” observed Friedman.

In the early 1980s the Medicaid claims processing colossus felt its first significant growing pains. From the outset Medicaid had covered a core set of services. “Everybody on Medicaid got the same basic service, no more, no less,” said Alan Shugart. Shugart is senior health care policy analyst at CMS and former Director of Maryland's Medicaid operations. “The systems were built around that very simple concept: just one standard set of services, and one standard payment system.”

President Ronald Reagan soon changed that, and forever altered the system of Medicaid eligibility and costs. In the 1980s a child named Katie Beckett caught President Reagan's attention when he learned that she only qualified for Medicaid when she was hospitalized, but not when she was at home. At home, Medicaid had to count her parents' income in determining her eligibility, but in the hospital it did not.

The “Katie Beckett Waiver”, as it became famously known, opened the door to a tide of waivers, each expanding Medicaid eligibility, adding new covered services, bringing in new non-medical providers, and introducing advocacy groups.

States began regularly to seek waivers for new services they might provide their electorates, pressing for Federal reimbursements at the highest rates. The effect was to put constant pressure on the boundaries of covered services. It was countered by those who favored “strict construction” of the claims payment strategy, and who saw the state press for waivers as nothing short of a raid on the United States Treasury.

There emerged, then, a “taffy pull” between the “Feds” and the states, observed Friedman. “There was a natural effort by the Feds to control the costs of these systems. When we made the boundaries of what was reimbursable a little looser or fuzzier,” he said, “one waiver would lead to the next. It made it harder to draw that definitive boundary on eligibility that would then stay fixed for all time.”

The MMIS systems adapted poorly to the demand for customization. Originally large, expensive mainframes, designed to minimize then-very expensive data storage and streamlined for quick claims payment, the systems were built to pay like claims alike, and do so quickly, and inexpensively. Where before the rule had been “everybody gets the

same,” waivers introduced a demand for customization. Programming and reporting added costs, complexity, and delays.

The advent of health maintenance organizations further taxed the core systems. “The MMIS really was driven by fee-for-service,” Friedman said. “When you wind up with encounters handled at the Harvard Community Health Plan, it doesn’t always work. States would then figure out ways to add pieces to their MMIS to try to accommodate that. But what Massachusetts did could be completely different from what California did. And there was very little guidance or anything else from the Feds from an IT perspective to really address that.”

With complexity mounting, the industry consolidated on a small number of large IT firms which had developed successful claims processing engines. They could deliver core functionality and assure swift Federal approval of state systems, keeping the reimbursement pipe open and dollars flowing. Federal certification of systems – a necessity – provided states with disincentives to “switch horses” lest they risk losing Federal matching funds from untested new providers. The consolidations of the marketplace became embodied in RFPs which required that the provider be proven, and have certified models.

In some market spaces the benefits of such same-firm consolidation might create de facto standards, streamline communications, and perhaps reduce costs. For MMIS, however, neither the states nor the Federal government gained such advantage. To the contrary, what emerged was a patch-work of idiosyncratic features tailored to state requirements, proprietary in nature, few interoperable.

“As firms customized state-by-state, they were not always bringing in their best features,” Friedman explained. “The offers were only what the states asked for. So if firms had a better idea for one state, they didn’t necessarily add it to their inventory of basic core systems – even though the Federal government essentially paid them to develop it – and bring over all the enhancements. A state had to ask for it to get it, and then had to pay for it. Again.”

Nor did innovations spread easily. Niche players might arise with modularized products to detect fraud and abuse, for example, or a data warehouse expertise, decision support systems, or immunizations registries. But with the MMIS architectures proprietary and source code held closely, the systems accommodated such innovations slowly.

Towards the end of the decade, a profound and intractable disconnect had surfaced within the MMIS enterprise, between the implicit strategy and attendant capability of infrastructure machines designed and built to pay like claims alike fast, and the dynamic requirements of a community of politicians, providers, and beneficiaries

whose disparate information needs could be addressed by MMIS poorly, if at all. “We kept trying to do patchwork fixes to this antiquated concept to try to address these things, and did it rather poorly,” Friedman said. There was a need to change something.

### **Enter Y2K and HIPAA: Lessons In Community**

In the latter part of the ‘90s, and crossing into the new millennium, two events further shaped the trajectory of the MMIS. Each had the effect of coalescing the diaspora of state-level Medicaid professionals into a community that discovered, in the near term, a shared set of quite technical problems. Over the longer term they gained an awareness of themselves as a group of like-minded professionals, soon to be linked by email and web, which could quickly frame issues and address a range of common challenges.

The first event, the Y2K conundrum, coalesced the state MMIS community around a potentially cataclysmic technical issue. “Y2K meant states had to begin to communicate across departmental lines, not in their separate silos,” said Denise Bazemore. Bazemore is CMS’ Technical Director within the Division of State Systems. “They actually had to start talking to each other within their own state government, as well as across state governments.”

The second, the Health Insurance Portability and Accountability Act (“HIPAA”) brought states together to resolve issues of disparate coding practices. HIPAA sought to establish a uniform national claims payment vocabulary, and required states to agree on a common approach to coding. “Fifty different MMIS systems that don’t really speak to one another,” Bazemore observed, “and each coded differently!”

Federal agencies left this particular challenge largely to the states to sort out, as the complexities and consequences of any heavy-handed Federal intervention in dictating universal coding could be catastrophic. Federal agencies could neither know all the codes in use in every state, nor their definitions, nor the ramifications should they mandate a “one size fits all,” they left it to the states to sort out.

Rick Friedman’s team at the Center for Medicaid and State Operations (CMSO) within CMS had responsibility for facilitating the state-to-state HIPAA effort. CMSO developed some basic tools, models and guides that helped states focus on the task ahead.

“We put out some roadmaps for states to measure their gaps and what they needed to do to modify MMIS to comply with HIPAA,” Bazemore said. “We identified a HIPAA contact in every state, put it on our website at CMS, and convened conferences. This was really the beginning of a network. People could call one another, could all talk in the same language, and talk about how to come into compliance with HIPAA.” The HIPAA

mandates thus yielded a first formal network of state-based HIPAA contacts maintained by the Federal agencies.

“Before this,” Friedman observed, “Medicaid state staff from around the country, based on personal contacts, would have some friends in certain states that they could pick up the phone and talk to, but they didn’t really have a national United Nations of people with like interests that they could easily connect with. But through the HIPAA local code effort, people were beginning to work together and see that there was a common distribution list of people across the country that were all focusing on different aspects of a common and universal IT problem. And, because of the forces that were driving states to respond to HIPAA, you could begin to identify this pool of people. It helped you understand that you weren’t alone, and it wasn’t just based on your personal contacts.”

It was a welcome development for a group of state leaders in high stress jobs where continuity of service was always an issue and hardly guaranteed. “There’s a lot of turnover in Medicaid,” Friedman observed. “The average organizational lifespan of a Medicaid director is something like two and half years. They used to do oil portraits of them but now they take Polaroids. They needed this kind of networking effort for the purpose of connecting in some sustainable institutional way on IT challenges.”

And, it laid the foundation for the Medicaid IT Architecture (“MITA”) initiative that would soon evolve.

### **The Community Evolves**

Through the contacts, dialogue emerged and like-minded souls found each other.

“There was this sort of band of renegades,” Friedman recalled, “who felt that IT ought to be used for information processing to help make judgment calls and help decision-makers look into the future, use data mining tools to look at patterns – to broaden the boundaries from simply a system that chugs along and processes a claim. These were state folks, people in the industry, people with some of the large and small IT firms who had a broader vision that reflected the value of information technology.”

“That group,” Friedman said, “started to see some connections with HIPAA, with Y2K, and saw an opening to try to build on that vision to permit states and systems to share information.”

The technology, too, was changing from the original days of MMIS. “Distributed systems were breaking down the big legacy boxes in refrigerated rooms into geographically disparate locations,” Friedman assessed. “This added pressure on the definition of a rigid boundary of the system when flexibility in geography could push boundaries out further and further.” Even the concept of a “state” -- from an IT

perspective -- might begin to erode. “With distributed architecture, what difference does it make where something is geographically located as long as it’s connected electronically and the data shared?”

Indeed, important work envisioning the next generation of MMIS was already under way. Arthur McKay and Susan Fox, influential industry consultants, spear-headed a Private Sector Technical Group supporting HCFA, and in the late 1990’s documented a vision for MMIS that took stock of its present ills and future prospects. Their report “probed the possibilities of rejuvenation, rebirth, and cloning for our Medicaid systems,” addressing such issues as the potential for shared or distributed arrangements, and the role of proprietary software and the merits of customized systems.<sup>2</sup>

Elsewhere, innovation percolated among a few states. Oregon capitalized on its Y2K community to create a framework for sharing among its several social services agencies, for example, and brought it forward at national meetings of Medicaid directors. Friedman saw this process and encouraged other states to join. Ten state “thought leaders” comprised themselves as an advisory group to CMSO, dubbed the “State Technical Advisory Group”, or S-TAG, and convened in regular monthly consultations. In 2002, the S-TAG submitted a report which it described as “a first attempt at defining a MMIS business model that is common to all states,” and set three objectives for any future MMIS:

- To provide quality healthcare to members by providing access to the right services to the right people at the right time for the right cost,
- To build an MMIS enterprise model which will integrate with other state human service information systems, (not just a “stand-alone” MMIS),
- To become more client focused by expanding the system focus beyond being claims and provider centric.<sup>3</sup>

CMSO brought forward the S-TAG group’s report to a national MMIS directors’ meeting in the spring of 2002 and received broad endorsement for MMIS “improvements” in a number areas, including

- Data integration at the individual, provider and system levels
- Data validation and quality assurance beyond that which is needed for claims payment
- Partnerships between state Medicaid agencies and Medicare, other insurers and other state agencies
- Fraud and abuse detection

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<sup>2</sup> *Steps Needed to Improve State Medicaid Information Systems*. The Private Sector Technical Group (PS-TG). October 15, 1997 <http://www.pstg.org/21centmmis.htm#contributors>

<sup>3</sup> Joyce, Jim et al. *State Technical Advisory Group (S-TAG) MMIS Definition*. Draft Document Version 1. June 8, 2002

- Quality of care through better feedback to providers and users
- Information (rather than simply data) sharing
- HIPAA compliance
- Data standardization across Agencies and to the national level
- Real-time claims processing
- Standard consolidated financial systems and
- Comprehensive, electronic documentation

Friedman's team was resolved to capture the momentum and accelerate change, and sought technical assistance and bandwidth. "We realized we needed some outside help to help us think through some of these ideas that were beginning to emerge as a result of reaching out to the states and the industry," Denise Bazemore said. The problem was money to finance that assistance, and authority to go forward.

For these purposes, Friedman had neither.

### **Funding and Budget**

"We were on a budget track under CMS' Information Technology Review Board (the "ITRB")," explained Denise Bazemore. The ITRB is the high-level cross-agency group that sets CMS budget priorities. As Medicaid, CMSO was a low priority for IT development funds next to Medicare.

Friedman characterized the CMSO budget situation this way.

ITRB ranks all projects using a combination of factors, many of which quite understandably need to address the Secretary and Administrator's Medicare-related priorities and concerns, including those mandated by Congress. Inevitably Medicaid IT priorities are rather low, in part because the Medicaid IT systems are, in the end, viewed as being much more of a state's responsibility than the federal government's. This may seem counterintuitive to people outside of the government, particularly in light of the fact that, between what the states and federal government together spend, Medicaid is even larger than what we spend on Medicare. But the original legislation is very clear. The Medicaid program is "owned and operated" by the states, whereas the Medicare program is solely the federal government's responsibility.

Worse, still, Friedman's team was proposing soft vision "stuff" – guidelines, standards, principles that might further advance the national goals of data sharing found in the McKay and Fox report, the S-TAG group, and elsewhere. It was not software development. The ITRB, CMSO's budget home, funded software development.

“With Y2K we had a budget on the order of ten million dollars,” Denise Bazemore said. “Every project we would put in after that kept getting put into this same track. And, every time we would ask for additional money above and beyond Y2K, we had to justify why the ITRB should fund a non-software project, especially one for Medicaid. We’d argue constantly but never get funding. It was a disaster for us.”

“One of the dilemmas of being below the radar, as we were then,” said Friedman, “is that you don’t have many in-house champions to fight your budget battles.”

“So one of the things we had to do,” Bazemore observed, “was to move our project development into an administrative budget track.” It wasn’t perfect – the CMSO group still competed as Medicaid against Medicare for “admin” dollars, but at least CMSO could propose programmatic development that did not compete head-on with software development on an IT track.

Using the administrative budget track, Friedman’s group secured a first year appropriation of \$800,000 to fund consultants to help CMSO document a new path for MMIS. It was enough to give Friedman and his staff the latitude to move, and it came with few strings.

“The folks at the top of the organization tend to focus on the \$275 billion program dollars that go to paying Medicaid providers,” explained Friedman. The Medicaid IT “spend”, at less than \$2 billion, was small by comparison. “As long as we kept people informed and they had confidence that we knew what we we’re doing, we had the latitude to move forward.”

## **First Moves**

“It’s very important to work on the business vision first,” Friedman observed. The opportunity was at hand to rethink the world of Medicaid and the technology that might support it, not from the perspective of what MMIS would permit, but from what its various customers might require.

With 51 different MMIS operations, the “business” of Medicaid varied significantly. “Once you get past the overall single-sentence mission,” Friedman assessed, “how they actually interpret that mission varies from state to state, and in a place like California, from county to county.”

State support was critical because that is where the MMIS and MITA funds were spent. “One of the beauties of Medicaid, of course,” said Friedman, “is that it is a partnership between the federal government and the states. Ultimately, the states are the ones with contracts, using their share of IT dollars and our match, and the responsibility

to own and operate these IT systems. So it is very important that we develop this partnership.”

It was not a blank check. “CMS’ role is somewhat akin to that of an investor,” Friedman explained. “The states need to explain to us how they intend to make prudent IT decisions with the federal taxpayers’ dollars. We set the rules, and they have to submit plans that comport. So we wind up with a significant amount of influence. But the buck really stops with the states when it comes to all aspects of Medicaid. They are the ones ultimately responsible for the success or failure of their programs.”

Collaborative moves that were bold but non-disruptive were called for – to move forward aligned, not just with the states and the Federal government, but with system vendors.

“Medicaid is really from an IT perspective a three-legged stool,” observed Bob Guenther, another senior level systems executive at CMS, and with deep industry experience. “We could define this architecture any way that we wanted to, and we could try our best to get the states and the CIOs to buy-in. With luck, we could even figure out how to fund it. But if industry was not willing to come in and provide solutions that were compatible with our architecture, we were going nowhere.”

In the fall of 2002, CMSO retained Computer Sciences Corporation, which in turn brought on Fox Systems, the firm that had led the Oregon requirements definition initiatives, to partner in developing both a technical and business vision of the future of the MMIS world. The project was titled Medicaid Information Technology Architecture, and was referred to, thenceforth, as “MITA” (pronounced, MY-tuh)

CMSO’s goal was to find a vision for Medicaid that would comprise an agreed-to set of capabilities and functionalities for the Medicaid program for all 50 states and the District of Columbia. It would by its requirements and standards assure interoperability and confer flexibility, permitting states to craft unique solutions to their particular healthcare challenges, while assuring that data could flow within and across state Medicaid systems.

It took a year of surveys, analysis, conversations, and digests – creating an overlay of state visions for Medicaid, “one on top of the other like Venn diagrams,” Friedman said, to find the core set of functionalities that could comprise a common Medicaid program vision -- “an overlay that if you were to drive a stake through would hit all states.”

The findings described a new set of opportunities for the MMIS and pointed CMSO toward crucial new capabilities for a MMIS overhaul, including:

- Common standards with, but not limited to, Medicare
- Interoperability between state Medicaid organizations within and across states, as well as with other agencies involved in healthcare
- Web-based access and integration
- Software reusability
- Use of commercial off the shelf software
- Integration of public health data

“The deliverables out of the first year’s contract were important in that they got a lot of buy-ins as we went to the May 2003 MMIS conference,” Bazemore said. “The survey instruments, blueprints of systems, large pictorial depictions of what we meant by the vision and the mission were tangible products,” she continued.

In fact, CMSO pursued an aggressive campaign to engage the Medicaid community on behalf of this vision, ranging from local consultations to national briefings. “We wanted to get as much agreement to the vision going in the early stages as we could,” Bazemore said.

As they championed the vision, they learned, also, of emerging ad hoc attempts, like Oregon’s, Oklahoma’s, and Pennsylvania’s, to implement MITA-like capabilities. Even without heavy-handed central direction from CMSO in Baltimore, innovation around cross-boundary data sharing was beginning to take place.

By late 2004, Friedman’s team was resolved to bring its “early adopter states” together to rally the troops, and further clarify the vision of interoperability and cross-domain information sharing. How were implementers on the “bleeding edge” moving on elements of the vision? What barriers or hindrances were they encountering? What more should the Federal government be doing to clear the path and support the state-level work?

He was also concerned to put some limits on the early adopters before they raced too far ahead of the mainstream. Many initiatives, MITA-consistent as they might be, still could not be reimbursed under strict MMIS guidelines. “We were constantly trying to sort of push the toothpaste back up into the tube when it would squirt out in a different direction from where we were,” Friedman explained. States had to be careful, and Friedman had to be conservative.

The key would be the ten CMS Regions. Whenever a state wanted Federal support for system enhancements, the Federal government required it to submit an Advanced Planning Document (APD) to its Regional office showing costs and how it met CMS requirements. It was among CMSO’s responsibilities to offer interpretations of the

rules – many of which had been written years earlier -- to guide the CMS reviewers, and the Region's task to implement them.

Friedman was concerned to communicate a MITA-consistent set of requirements over to the Regions quickly to assure that should an early adopter surface with an APD, its Region would have the right framework to evaluate it. If CMSO were successful, all Regions would soon start seeing an up-tick of MITA-like proposals. Friedman needed to engage the Regions, and soon.

### **The Savage Mill Meeting**

On April 12 and 13, 2005 CMS convened sixteen “early adopter states” in Savage Mill, Maryland, an old historical mill town just southwest of Baltimore to take stock of the effort and calibrate. They included Iowa, Massachusetts, New Jersey, Florida, Ohio, New Mexico, Texas and others. Colleagues who comprised the STAG were there. So too were Federal officials who represented forward thinking supporters as well as more resistant traditionalists.

CMS was principally concerned to understand the current flurry of activity and how it fit against the current version of the vision, and what more would be required to keep reform moving. “They were each taking pieces of the MITA vision and including that -- attaching it to -- the legacy systems, or starting to build new systems,” explained Friedman. “We wanted to see what pieces resonated with which state under what set of circumstances, what made sense, was doable, and in a cost range that was not completely out of the picture.

The Savage Mill states, as early adopters, were particularly important for the MITA effort, as their stories would be among the first accounts of success that CMSO could share broadly. The verdict was mixed. Many were at the conceptual level still. But some showed promise of breakthrough. The State of Pennsylvania was one such.

“Pennsylvania's was a potential breakthrough in that their MMIS claims processing system for Medicaid was a parallel system to another agency's, the Department of Mental Health, which had a similar system that we didn't consider part of the MMIS because it's outside of the silo,” Friedman recounted. “They showed us the functionality in this mental health system, which looked a lot like what we were talking about in MITA and to the degree that the two systems could be merged or interfaced. That was a step in the direction of interoperability.”

Reviewing progress, CMSO also gained awareness of just how fragile these early stage innovations could be. “In Ohio, an especially critical state,” Friedman recalled, “there was a key decision-maker who got it, who was articulate, who was dynamic,

absolutely wonderful and saw the light, and left state government. As soon as she left, that project began to falter.” Somehow this wave of good effort needed to be staked to firm, real-world anchors to withstand such turbulence.

The early adopter states were beginning to take on elements of the MITA vision. CMSO worried about assuring consistency. The distributed innovation terrain was of necessity “messy”; but 50 states and the District going off in wildly different directions would surely create chaos. At the very least, the CMS Regional Offices would require some way to systematically sort through the noise when MITA-based APDs from the states started flowing

The idea of a “MITA Maturity Model” emerged. As a common approach in the world of IT it might give any state the ability, via a self-assessment tool, to standardize its move to MITA and provide both CMSO and the states with a yardstick to evaluate a state’s APD.

“We were going to need to put our arms around what we really meant by this fuzzy thing called ‘MITA’,” Friedman observed. A maturity model could be a great framework. It was clear that the states wanted specifics. “You can talk about something all the time year after year,” reflected Bazemore, “but when it comes to the users they want to know, ‘How do I even start this process? What do I need to get started? Show me the steps.’”

The CMSO team realized that while much had been accomplished, a major documentation effort still lay ahead – updated vision, architectures, business plans, maturity models, essentially a Version 2.0 of the original CSC/Fox Framework.

Having fanned the brushfires of enthusiasm, the CMSO team now questioned its own ability to sustain the effort deep much past the planned publication of Ver 2.0 in early 2006. Its funds were running low and it would be unable to extend its own contractors’ terms. “Of necessity,” Friedman recalled, “We began to think about collaborations with states so that they would use their IT experts to help us.” And, new initiatives were arising such as eHealth where MITA might gain further support.

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Through 2005 and into 2006, the CMSO team continued its marketing and development, gearing towards presenting a definitive MITA Framework 2.0 to the 2006 MMIS conference. Friedman pursued dialogue with the ten Associate Regional Administrators, the top CMS federal officials responsible for Medicaid with “boots on the ground” across the country, communicating guidance on new rules his team drafted that reflected MITA requirements.

“It used to be in the old days when CMS received a state APD we had few standards beyond those described in our regulations. We’re now asking the states to lay out the APD against the MITA maturity model to show us how this improvement begins to move you along that pathway,” Friedman explained. A state might yet balk, Friedman allowed. But with the new rules in place, and the groundwork laid, and a shared vision in the offing, the prospects seemed good for slow but steady migration to the MITA 2.0 framework.

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As it turned the corner of 2006, CMSO’s own resources were near exhaustion. It saw some promise of linkages to the emerging state-level eHealth initiatives from the Office of the National Coordinator for Health Information Technology, led by Dr. David Brailer. “Dr. Brailer’s activity was lighting a thousand fires across the country,” Friedman recalled. “We knew, if we could touch some of those fires, and make the connection between MITA and the governors’ initiatives in eHealth, we could attach our little wagon to those various stars and get pulled along successfully.” But that future was as yet uncertain. Brailer was keenly interested in clinical data. Clinical data existed only in small pockets in Medicaid – but Medicaid’ claims data still held a treasure trove of encounter information.

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What was certain was President Bush’s commitment to such eHealth initiatives. In his January 2006 inaugural address the President declared eHealth to be a priority for his second term.

As other agencies did, the Department of Health and Human Services spent the winter energetically developing plans to be in position to adapt its initiatives to the announced priority. By spring, HHS Secretary Mike Leavitt would bring forward the Department’s own strategy. The Secretary’s staff was in the hunt for initiatives that might demonstrate progress against the President’s goals, and be worthy of further investment.

“So, what are you guys doing on the Medicaid side?,” Friedman remembers being asked. “What are the states up to? Anything? Doesn’t look like much.”

And we said, “Well, no, actually, we *do* have a bit going on here. Let us tell you about it...”

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