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**Gap Analysis**  
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**Massachusetts MITA Assistance Project**  
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## Executive Summary

FourThought Group (4TG) has a contract with the Executive Office of Health and Human Services (EOHHS) to create an EOHHS Medicaid Information Technology Architecture (MITA) library of existing documentation, develop the As-Is components of the Business Capability Matrix (BCM) and the Technical Capability Matrix (TCM) using only the documentation provided by EOHHS, and complete a Gap Analysis to identify areas that are lacking in the documentation necessary to conduct a State Self-Assessment (SS-A). This project, known as the Massachusetts MITA Assistance Project includes the following major milestones:

- ◆ Collect and load business documentation to create the EOHHS MITA library
- ◆ Develop the BCM based solely on documentation provided by EOHHS
- ◆ Develop the TCM based solely on documentation provided by EOHHS
- ◆ Provide EOHHS with a Gap Analysis Report indicating the BCM and TCM cells where the Maturity Level determination is incomplete or weak due to the lack of documentation provided by EOHHS.

As the single state agency responsible to the Centers for Medicare and Medicaid Services (CMS) for oversight of the Massachusetts Medicaid Program, EOHHS is committed to complying with the CMS MITA guidelines and requirements as it plans to modernize the business processes and associated enabling technologies used to operate the Massachusetts Medicaid Enterprise. For this project, known as Component One (C1), the Massachusetts Medicaid Enterprise is strictly limited to EOHHS, Office of MassHealth.

CMS requires states to use the Business Process Model (BPM), provided as Appendix A of the MITA 2.0 Framework, and the Business Capability Matrix (BCM), provided as Appendix D of the MITA 2.0 Framework to conduct a State Self-Assessment. The SS-A is intended to establish a baseline for states that can be used throughout the lifecycle of a state's plan to transition from current business capabilities to future targeted capabilities. This Gap Analysis Report is a critical component of the Massachusetts SS-A, presenting those areas and processes for which a MITA Maturity Level could not be determined due to incomplete or missing documentation. This report also offers EOHHS recommendations for collecting or creating the missing information, which will enable EOHHS to complete a full SS-A.

To produce the BCM Report, the TCM Report and this Gap Analysis Report, 4TG used information gathered from documentation and links to the Mass.gov website\* provided by EOHHS to analyze and validate a predefined set of measures for each business process and capability defined in the MITA 2.0 framework.

**\*Disclaimer With Regard to Website Links:** Because the Mass.Gov website is owned and operated by the Commonwealth of Massachusetts, the validity of the links referenced in the "Notes" section of the Maturity Assessment Tracking Tool (MATT) and produced on the associated reports cannot be guaranteed by 4TG. While the links were valid at the time the information was reviewed, they may no longer be valid as the result of revisions to the website by the Commonwealth

## Purpose

The Gap Analysis traditionally identifies the gaps between the Medicaid Enterprise As-Is capabilities and their To-Be targets. For purposes of this project, the Gap Analysis identifies those BCM and TCM cells where the Maturity Level determination was either incomplete or weak, due to missing or insufficient documentation. The identified gaps resulted in unaffirmed business or technical processes, capabilities, or functions and based on MITA guidelines default to a Maturity Level 1.

The purpose of this Gap Analysis is to identify the information gaps in the As-Is Assessments, where a Maturity Level could not be determined and therefore defaulted to Maturity Level 1, due to either a lack of documentation or documentation that does not provide sufficient detail to allow for a complete assessment of how the business and technical processes and capabilities are performed. This report provides EOHHS with the information necessary to move forward into Component Three (C3) of their MITA Assessment efforts, because it will indicate those business areas and processes where EOHHS may need to conduct interviews and meetings with subject matter experts (SMEs) to perform a complete MITA SS-A. Additionally, 4TG offers recommendations for ways to remedy the gaps.

### **Background**

MITA is modeled on other widely recognized capability maturity models, such as Software Engineering Institute's (SEI) Capability Maturity Model® Integration (CMMI). These models provide a process improvement approach for organizations by detailing the essential elements of effective processes. The 4TG As-Is Assessment methodology uses the MITA 2.0 maturity model and framework to guide process improvement by using defined measures to identify the Maturity Level for each business and technical process in the Medicaid Enterprise and for the Enterprise as a whole.

EOHHS is committed to presenting CMS with an SS-A for Massachusetts that is consistent with MITA principles, while customized to the unique processes of the Commonwealth. The BCM and TCM As-Is Assessments used the MITA Business Model and Technical Model to construct a point of reference by measuring the current EOHHS processes and determining the respective Maturity Levels for each. The Gap Analysis uses this point of reference to specify the business and technical processes that could not be assessed as the result of missing or insufficient documentation provided. By identifying these documentation gaps, EOHHS will be able to clearly see the information it needs to collect in order to conduct a full SS-A for the Massachusetts Medicaid Enterprise.

The Executive Office of Health and Human Services contracted with 4TG to facilitate, assist, and conduct the As-Is components of a MITA Assessment and to develop the following major deliverables:

1. Business Capability Matrix (BCM), that assesses the current (As-Is) business capabilities of the Medicaid Enterprise,
2. Technical Capability Matrix (TCM), which assesses the current (As-Is) technical capabilities of the Medicaid Enterprise,
3. Gap Analysis Report, which identifies those matrix cells for which a Maturity Level could not be determined due to lack of or incomplete documentation and offers recommendations for collection and or development of the missing documentation.

## **MITA Overview**

*The Medicaid Information Technology Architecture (MITA) is a roadmap and toolkit for States to transform their Medicaid Management Information System (MMIS) into an enterprise-wide, beneficiary-centric system. MITA will enable State Medicaid agencies to align their information technology (IT) opportunities with their evolving business needs. It also addresses long-standing issues of interoperability, adaptability, and data sharing, including clinical data, across organizational boundaries by creating models based on nationally accepted technical standards. Perhaps most significantly, MITA allows State Medicaid Programs to actively participate in the DHHS Secretary's vision of a transparent health care market that utilizes electronic health records (EHR's), ePrescribing and personal health records (PHR's).<sup>1</sup>*

MITA is an initiative of the CMS Center for Medicaid & State Operations (CMSO). MITA is intended to foster integrated business and IT transformation across the Medicaid Enterprise to improve the administration of the Medicaid program. MITA fosters integrated business and technology transformation of the State Medicaid Enterprise by providing a new process for States to plan technology investments, and design, develop, enhance or install Medicaid information systems. MITA provides a business-driven architectural framework, process model, and planning guidelines for States to define their strategic business goals and objectives, align their business processes with the MITA national model and assess their current capabilities as a baseline for measuring progress towards their Envisioned Future. MITA is designed to support and enable integrated business and technology transformation of the Medicaid Enterprise. The MITA Business Architecture is based on a Capability Maturity Model (CMM); the best known of which is the Software Engineering Institute's (SEI) Capability Maturity Model® Integration (CMMI). CMM and CMMI is a "process improvement approach that provides organizations with essential elements of effective processes" and "helps integrate traditionally separate organizational functions, set process improvement goals and priorities, provide

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<sup>1</sup> Richard H. Friedman, Medicaid Information Technology Architecture: An Overview, Health Care Financing Review, Winter 2006-2007, Volume 28, Number 2 <http://www.nasmd.org/issues/docs/Friedman.pdf>

guidance for quality processes, and a point of reference for appraising current processes.”<sup>2</sup>

### **Methodology**

To develop this Gap Analysis we reviewed the BCM and TCM As-Is Assessments based on the information contained in the documentation and links to the Mass.gov website\* provided by EOHHS in support of the Massachusetts Medicaid Enterprise (as defined in the Request for Responses (RFR) as Component One). Using MITA definitions, we aligned the information contained in the documentation with the MITA capabilities, answered questions related to the process characteristics to accurately measure each business capability, (i.e., time, function and quality), and subsequently determined a MIA Maturity Level for each business and technical process.

Based on the As-Is Assessment findings and reports generated from the 4TG Maturity Assessment Tracking tool (MATT), we identified those areas and processes for which a Maturity Level could not be determined, and therefore defaulted to Maturity Level 1, due to insufficient or missing documentation. We also offer recommendations for collecting or creating the missing information, so that EOHHS will be able to complete the SS-A.

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<sup>2</sup> Carnegie Mellon, Software Engineering Institute CMMI <http://www.sei.cmu.edu/cmmi/general/>

## MITA Business Capability Gap Analysis Findings

1. The MITA Gap Analysis provides EOHHS with a clear view of the gaps between the MITA guidelines necessary to affirm the MITA defined capabilities for each business or technical process and the information available in the documentation provided.

This report specifies the types of characteristics within each MITA business area for which there was either no documentation provided, or the documentation lacked sufficient detail to allow for a complete assessment of the business or technical area. Specific characteristics within the business areas consist of the following:

- ◆ Timeliness of Process
- ◆ Data Access and Accuracy
- ◆ Effort to Perform
- ◆ Efficiency
- ◆ Cost-Effectiveness
- ◆ Accuracy of Process Results
- ◆ Utility or Value to Stakeholders

Defined measures related to these characteristics are used to identify the MITA Maturity Level for each Business process in the Medicaid Enterprise, and lead to the cumulative Maturity Level for the Enterprise as a whole. For example, in certain processes, such as Manage Provider Information, a defined measure relating to the Data Access and Accuracy characteristic ascertains whether or not the staff performs updates manually. In order to affirm a Maturity Level for a single business process, every measure within that Maturity Level must be affirmed. Please note that the Technical Architecture is currently undefined within the MITA Framework 2.0 and does not contain characteristics or measures. As a result, levels within the Technical Areas are affirmed based on the overall implementation of certain technologies and technological concepts. The analysis presented below is organized to include the eight MITA business areas, the seven technical business areas and recommendations for each. The analysis includes:

- ◆ A description of each business process within the business area;
- ◆ An analysis of the gaps between the information in documents provided and the information needed for EOHHS to complete a full SS-A; and
- ◆ 4TG recommendations for obtaining the missing information.

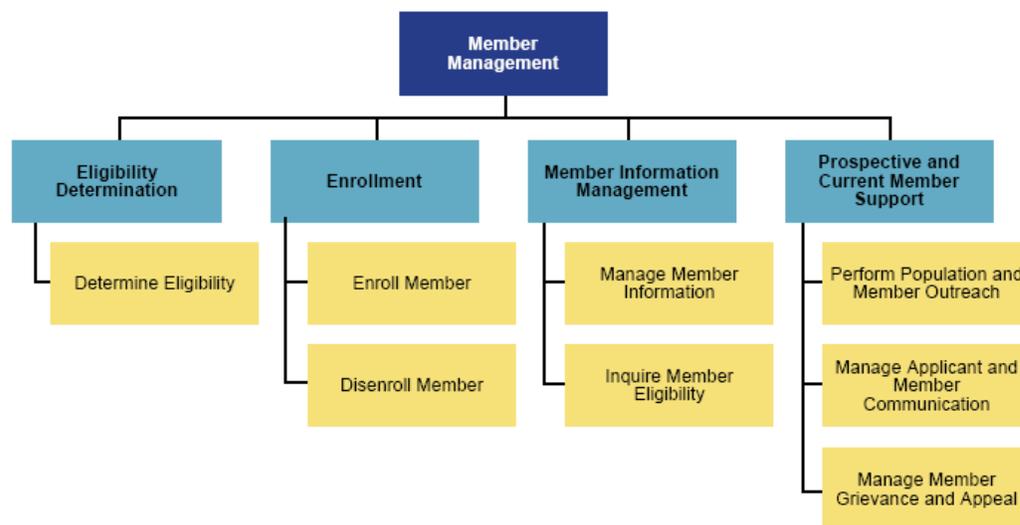
The MITA 2.0 framework provides for five Maturity Levels (1-5). Therefore, processes for which less than 100% of the Maturity Level 1 characteristics and measures can be affirmed, default to a Maturity Level 1. In the sections that follow, to differentiate

Maturity Level 1 determinations resulting from full affirmation of all measures from those that default to a Maturity Level 1, we annotate the default Maturity Level 1 designations as follows:

- ◆ 1\* – indicates that the information in the documentation provided was insufficient to affirm any of the characteristics and/or measures for a process or that no documentation was provided to address the process; therefore the Maturity Level defaulted to a Level 1.
- ◆ 1\*\* – indicates that 4TG was only able to partially affirm the measures for this business process based on the documentation provided; therefore the Maturity Level defaulted to a Level 1. The specific measures missing for each business process are identified in the Gap Analysis column.

## Member Management

### Business Area and Business Process Description



*The Member Management business area is a collection of business processes involved in communications between the Medicaid agency and the prospective or enrolled beneficiary and actions that the agency takes on behalf of the beneficiary. These processes share a common set of beneficiary-related data. The goal for this business area is to improve healthcare outcomes and raise the level of consumer satisfaction.*

*This business area is transformed in the future from agency staff performing eligibility and enrollment functions to more patient self-directed decision making.*

*Member Management business processes consolidate many eligibility and enrollment functions into a single, generic business process. Determine Eligibility, for example, covers Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), State Children's Health Insurance Program (SCHIP), and other programs. Enroll Member includes enrollment in managed care programs, carved-out benefit plans (e.g., pharmacy, dental, or mental health services), waiver service programs, and gatekeeper or lock-in programs.*

## Current Capability Maturity Assessment Results and Gap Analysis

The table below documents the Maturity Levels associated with the current processes within Member Management for the Massachusetts Medicaid Enterprise and provides a gap analysis for each business process within the Member Management business area.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Eligibility Determination - <i>Determine Eligibility</i>	<p>Receives eligibility application data set from the Receive Inbound Transaction process; checks for status (e.g., new, resubmission, duplicate), establishes type of eligible (e.g., children and parents, disabled, elderly, or other); screens for required fields, edits required fields, verifies applicant information with external entities, assigns an ID, establishes eligibility categories and hierarchy, associates with benefit packages, and produces notifications.</p> <p>Most States accept the designation of eligibility from other agencies (SSI, TANF, SCHIP, other), in which case this business process will not be used by the Medicaid agency for those individuals. In these situations, Medicaid receives and stores the member information sent from other sources in the Member Registry. This may require conversion of the data.</p> <p>However, this process will be used by the other states which require the TANF, disabled, elderly applicant to apply for Medicaid, and where the Medicaid agency determines eligibility for state-only programs.</p>	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided; therefore the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to: cost-effectiveness; staffing; and the efficiency, accuracy or quality of this business process.
Enrollment - <i>Disenroll Member</i>	Responsible for managing the termination of a member's enrollment in a program, including:	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided, therefore

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<ul style="list-style-type: none"> <li>▪ Processing of eligibility terminations and requests for disenrollment (submitted by the member, a program provider or contractor)</li> <li>▪ Disenrollment based on member's death; failure to meet enrollment criteria, such as a change in health or financial status, or change of residency outside of service area (requested by another Business Area, e.g., Prepare Member Payment Invoice process for continued failure to pay premiums or Program Integrity for fraud and abuse)</li> <li>▪ Mass Disenrollment due to termination of program provider or contractor</li> <li>▪ Validation that the termination meets state rules</li> <li>▪ Requesting that the Manage Member Information process load new and changed disenrollment information</li> <li>▪ Prompting the Manage Member Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including. The Capitation and Premium and Member Payment Management Areas business processes about changed Member Registry information for payment preparation--The appropriate communications</li> </ul>		<p>the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to the: timeliness; disenrollment data formats; storage of disenrollment records; staffing; or the efficiency, accuracy or quality of this business process.</p>

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights. Enrollment brokers may perform some of the steps in this process		
Enrollment - <i>Enroll Member</i>	Receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible (e.g., managed care, HIPP, waiver), loads the enrollment outcome data into the Member and Contractor Registries, and produces notifications to the member and the contractor. Either the Agency or enrollment brokers may perform some or all of the steps in this process.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided, therefore the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to the: format and storage of enrollment data/records; notifications to contractors; cost-effectiveness; staffing; or the efficiency, accuracy or quality of this business process.
Member Information Management - <i>Inquire Member Eligibility</i>	Receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process, which generates the outbound Eligibility Verification Response Transaction.  This transaction indicates whether the member is eligible for Medicaid health benefit plan coverage, per HIPAA, and may include more detailed information about the Medicaid programs, benefits and services, and providers from which the member may receive covered services.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided; therefore the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to the: timeliness of responses to providers; staffing; or the efficiency, accuracy or quality of this business process.
Member Information Management - <i>Manage Member Information</i>	Responsible for managing all operational aspects of the Member Registry -- the source of comprehensive	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided, therefore

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>information on applicants and members, and their interactions with the Medicaid Enterprise.</p> <p>The Member Registry is the Medicaid enterprise “source of truth” for member demographic, financial, socio-economic, and health status information. A member’s registry record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services. In addition, the Member Registry stores records about and tracks the processing of eligibility applications and determinations, program enrollment and disenrollment; the member’s covered services, and all communications, e.g., outreach and EOBs, and interactions related to any grievance/appeal.</p> <p>The Member Registry may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend-down information. Business processes that generate applicant or member information send requests to the Member Registry to add, delete, or change this information in registry records. The Member Registry validates data upload requests, applies instructions, and tracks activity.</p> <p>The Member Registry</p>		<p>the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to the: timeliness of updates to member information; availability of data for users; adequacy of audit trails; impact of system limitations on member updates; validation and reconciliation of member updates; or the efficiency, accuracy or quality of this business process.</p>

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>provides access to member records to applications and users via batch record transfers, e.g., for Medicare Crossover claims processing, responses to queries, e.g., for eligibility verification and Operations Management Area, and “publish and subscribe” services for business processes that track member eligibility, e.g., Care Management and Perform Applicant and Member Outreach. Among the business processes that will interface with the Member Registry are:</p> <ul style="list-style-type: none"> <li>- The Determine Eligibility process, which checks the Member Registry for status (e.g., new, resubmission, duplicate) and sends completed member eligibility record to be loaded into Member Registry.</li> <li>- The Enroll and Disenroll Member processes, which send and retrieve member information relating to these processes, such as member’s ability to access providers, and plan and provider preferences</li> <li>- The Perform Applicant and Member, Manage Provider, and Manage Contractor Communications processes, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring these communication processes to prepare notifications</li> <li>- The Perform Applicant and Member Outreach, which tracks alerts from the Member Information process about information additions of changes in the Member</li> </ul>		

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>Information Registry that meet rules requiring provision of outreach and education to the affected applicant or member</p> <ul style="list-style-type: none"> <li>- The Perform Applicant and Member Communication process, which schedules the face to face or phone interview, receives an application, or receives a referral, logs in request and prepares a package of eligibility information which is sent to the Determine Eligibility Process</li> <li>-All Operations Management business processes, e.g., Manage Member Payment, Edit Claim/Encounter, and Authorize Service</li> <li>- The Maintain Benefit/Reference Information process, which is the Member Registry’s source of benefit package information</li> <li>- The Manage Program Information business process, which consolidates key enterprise data for use in reporting, analysis and decision support</li> <li>- Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Member Registry for member information</li> <li>- Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Member Registry.</li> </ul>		
<p>Prospective and Current Member Support - <i>Manage Applicant and Member Communication</i></p>	<p>Receives requests for information, appointments and assistance from prospective and current members’ communications such as inquiries related to</p>	<p>1**</p>	<p>4TG was only able to partially affirm the measures for this business process based on the documentation provided, therefore the Maturity Level defaulted to a Level 1. The Maturity Level 1</p>

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and produced for distribution via Send Outbound Transaction process.</p> <p>Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bidirectional communication. Also included are scheduled communications such as Member ID cards, redetermination notifications, or formal program notifications such as the dispositions of grievances and appeals. The Perform Applicant and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues.</p>		<p>measures unable to be affirmed are related to the validation of responses, (e.g., call center audits; member satisfaction surveys) and the quality of the information members receive.</p>
<p>Prospective and Current Member Support - <i>Manage Member Grievance and Appeal</i></p>	<p>Handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Applicant and Member Communication process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance</p>	<p>1</p>	<p>4TG was able to fully affirm this business process at Maturity Level 1. However, 4TG was unable to affirm any of the characteristics and/or measures at a higher Maturity Level based on the documentation provided.</p>

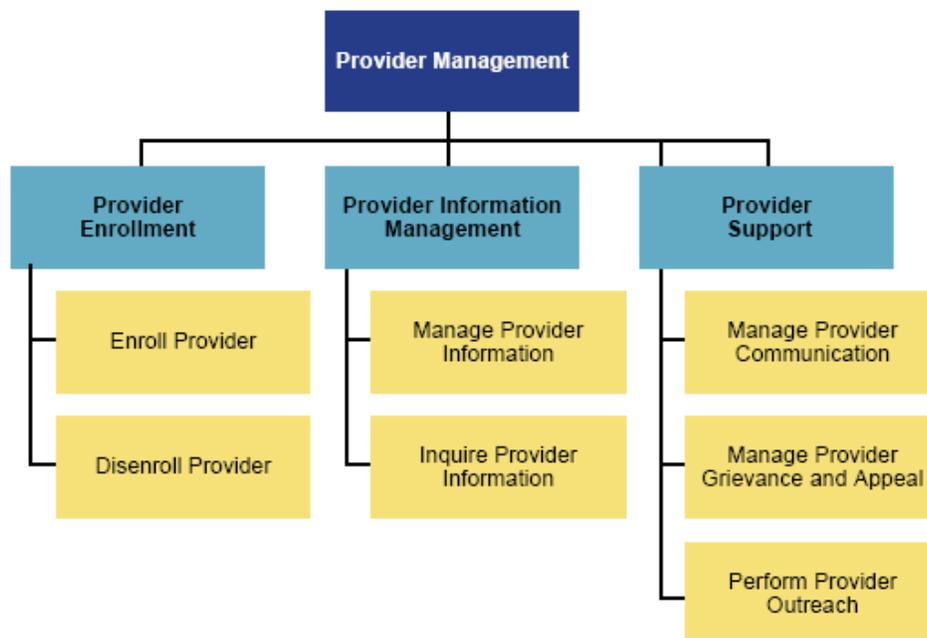
Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file.</p> <p>The applicant or member is formally notified of the decision via the Send Outbound Transaction Process. This process supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. In some states, if the applicant or member does not agree with the Agency's disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or member is urgent, the appeal may be expedited.</p> <p>States define "grievance" and "appeal" differently due to state law, however, States must enforce the Balance Budget Act requirements for grievance and appeals processes through their MCO contracts (42 CFR Part 438.400), and may adopt these for non-MCO programs.</p>		
Prospective and Current Member Support -	Originates internally within the Agency for purposes such as:- Notifying	1**	4TG was only able to partially affirm the measures for this business process based on the

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
<p><i>Perform Population and Member Outreach</i></p>	<p>prospective applicants and current members about new benefit packages and population health initiatives- New initiatives from Program Administration- Indicators of underserved populations from the Monitor Performance and Business Activity process (Program Management).It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children's Health Insurance Program (SCHIP).</p> <p>Outreach information is developed for targeted populations that have been identified by analyzing member data. Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction and the Manage Business Relationship Communication process. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.</p> <p>The Perform Population and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues. Inquires from applicants, prospective and current members are</p>		<p>documentation provided; therefore the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to: timeliness; cost-effectiveness; impact of member outreach, and education and population targeting; staffing; and the accuracy, efficiency and quality of this business process.</p>

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bidirectional communication.		
1** – indicates that 4TG was only able to partially affirm the measures for this business process based on the documentation provided; therefore the Maturity Level defaulted to a Level 1.			

## Provider Management

### Business Area and Business Process Description



*The Provider Management business area is a collection of business processes that focus on recruiting potential providers, supporting the needs of the population, maintaining information on the provider, and communicating with the provider community. The goal of this business area is to maintain a robust provider network that meets the needs of both beneficiaries and provider communities and allows the State Medicaid agency to monitor and reward provider performance and improve healthcare outcomes.*

*The Provider Management business processes cover many types of providers. In this case, Enroll Provider may subdivide into Enroll Institutional Provider, Professional Provider, Pharmacy, Durable Medical Equipment (DME), Atypical, and other types. These groups are types together in the BPM because they share a common set of activities, though the business rules and specific data associated with each provider type may differ.*

## Current Capability Maturity Assessment Results and Gap Analysis

The table below documents the Maturity Levels associated with the current processes within Provider Management for the Massachusetts Medicaid Enterprise and provides a gap analysis for each business process within the Provider Management Business area.

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
Provider Enrollment - <i>Disenroll Provider</i>	The Disenroll Provider business process is responsible for managing providers' enrollment in programs, including: <ul style="list-style-type: none"> <li>- Processing of disenrollment</li> <li>-- Requested by the provider</li> <li>-- Requested by another Business Area, e.g., the Manage Provider Communication, Monitor Performance and Business Activities, and Program Integrity Manage Case processes</li> <li>-- Due to receipt of information about a provider's death, retirement, or disability from the Manage Provider Communication process</li> <li>-- Based on failure in the Enroll Provider process, e.g., Provider fails to meet state enrollment requirements</li> <li>--- Provider fails enumeration or credentialing verification</li> <li>--- Provider cannot be enumerated through NPPES or state assigned enumerator</li> <li>--- Lack of applicable rates</li> <li>--- Inability to negotiate rates or contract</li> <li>- Tracking of disenrollment requests and records, including assigning identifiers and monitoring status (e.g., new, resubmission, duplicate)</li> <li>- Validation that the disenrollment meets state rules and substantiating basis for disenrollment, e.g., checking death records</li> <li>- Requesting that the Manage Provider Information process load initial and changed disenrollment information into the Provider Registry</li> <li>- Prompting the Manage Provider Communication process</li> </ul>	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided. Therefore, the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to: increased value to stakeholders, staffing or whether they have time to focus on linguistic compatibility, member satisfaction, or provider performance; and the efficiency of this business process

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>to prepare disenrollment notifications and instructions for closing out provider contracts for generation and transmission by the Send Outbound Transaction process</p> <ul style="list-style-type: none"> <li>- Prompting the Manage Provider Information process to provide timely and accurate notification or to make disenrollment data required for operations available to all parties and affiliated business processes, including               <ul style="list-style-type: none"> <li>-- The Capitation and Premium Payment Area</li> <li>-- The Prepare Provider EFT/Check process</li> </ul> </li> <li>- Prompting Manage Applicant and Member Communication process to notify and reassign, where necessary, members who are on the provider’s patient panel, e.g., PCCM, Lock-in, HCBS and other waiver program, and FFS</li> <li>- Prompting Perform Applicant and Member Outreach to provide appropriate outreach and educational material to displaced members</li> </ul>		
<p>Provider Enrollment - Enroll Provider</p>	<p>The Enroll Provider business process is responsible for managing providers’ enrollment in programs, including - Receipt of enrollment application data set from the Manage Provider Communication process- Processing of applications, including status tracking (e.g., new, resubmission, duplicate) and validating application meets state submission rules, e.g., syntax/semantic conformance- Validation that the enrollment meets state rules by -- Performing primary source verification of verifies provider credentials and sanction status with external entities, including:--</p> <ul style="list-style-type: none"> <li>- Education and training/Board certification---</li> <li>License to practice---</li> <li>DEA/CDS Certificates---</li> <li>Medicare/Medicaid sanctions---</li> <li>Disciplinary/sanctions against</li> </ul>	<p>1**</p>	<p>4TG was only able to partially affirm the measures for this business process based on the documentation provided. Therefore, the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to: increased value to stakeholders, staffing or whether they have time to focus on linguistic compatibility, member satisfaction, or provider performance; accuracy of this business process</p>

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>licensure--- Malpractice claims history--- NPDB and HIPDB disciplinary actions/sanctions-- Verifying or applying for NPI enumeration with the NPES-- Verifying SSN or EIN and other business information- Determine contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill- Establish payment rates and funding sources, taking into consideration service area, incentives or discounts- Negotiate contracts- Supporting receipt and verification of program contractor's provider enrollment roster information, e.g., from MCO and HCBS organizations- Requesting that the Manage Provider Information process load initial and changed enrollment information, including providers contracted with program contractors into the Provider Registry - Prompting the Manage Provider Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including:-- The Capitation and Premium Payment Area-- The Prepare Provider EFT/Check process-- The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights- Perform scheduled user requested:-- Credentialing re-verification-- Sanction monitoring-- Payment rate negotiations-- Performance evaluationExternal contractors such as quality assurance and credentialing verification services may perform some of these steps</p>		
<p>Provider Information Management - <i>Inquire Provider Information</i></p>	<p>The Inquire Provider Information business process receives requests for provider enrollment verification from authorized providers, programs or business</p>	<p>1**</p>	<p>4TG was only able to partially affirm the measures for this business process based on the</p>

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.</p>		<p>documentation provided. Therefore, the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to the accuracy of this business process</p>
<p>Provider Information Management - <i>Manage Provider Information</i></p>	<p>The Manage Provider Information business process is responsible for managing all operational aspects of the Provider Registry, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the state Medicaid. The Provider Registry is the Medicaid enterprise “source of truth” for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The Registry includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services. In addition, the Provider Registry stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and all communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal. The Provider Registry may store records or pointers to records for services requested and services provided; performance, utilization, and program integrity reviews; and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member Registry to add, delete, or change this information in</p>	<p>1**</p>	<p>4TG was only able to partially affirm the measures for this business process based on the documentation provided. Therefore, the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to: staffing and the accuracy of this business process</p>

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>registry records. The Provider Registry validates data upload requests, applies instructions, and tracks activity. The Provider Registry provides access to member records to applications and users via batch record transfers, responses to queries, and “publish and subscribe” services. Among the business processes that will interface with the Provider Registry are- The Enroll and Disenroll Provider processes, which send and retrieve provider information relating to these processes such as application, credentialing and enumeration review status- The Provider Support processes, such as Manage Provider Communication- All Operations Management business processes, e.g., Edit Claim/Encounter, Apply Mass Adjustment, Authorize Service, and Prepare Provider EFT/Check- The Maintain Benefit/Reference Information process, which is the Provider Registry’s source of benefit package information- Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Provider Registry for provider information - Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Provider Registry</p>		
<p>Provider Support - <i>Manage Provider Communication</i></p>	<p>The Manage Provider Communication business process receives requests for information, provider publications, and assistance from prospective and current providers’ communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via Send Outbound Transaction process. Note: Inquires from prospective</p>	<p>1</p>	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address whether automation led to fewer staff. This</p>

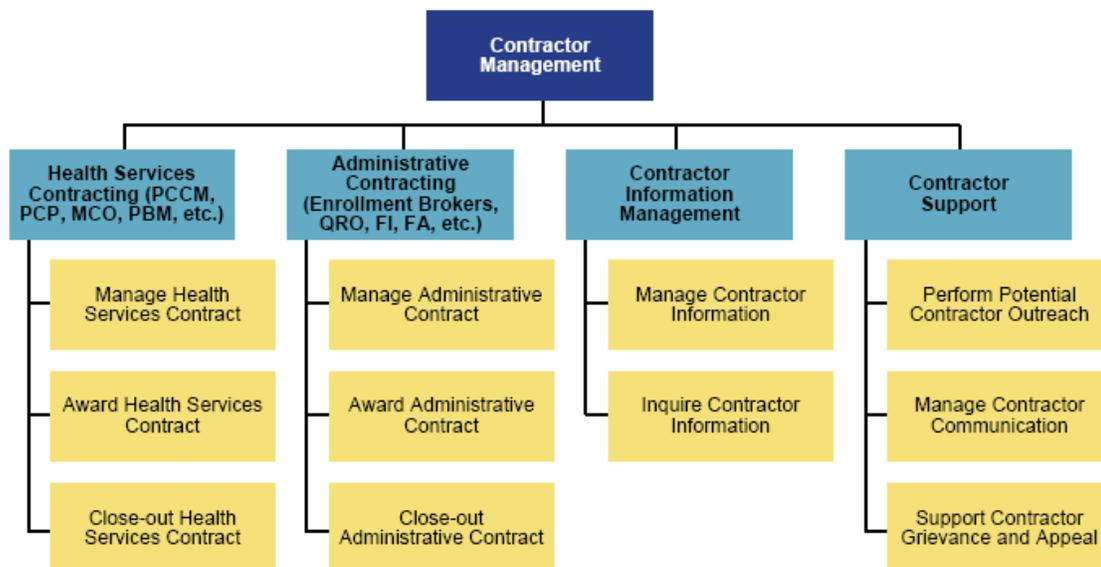
<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>and current providers are handled by the Manage Provider Communication process by providing assistance and responses to individual entities, i.e., bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The Perform Provider Outreach process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues.</p>		<p>information could be used to potentially affirm this process at a Level 2.</p>
<p>Provider Support - <i>Manage Provider Grievance and Appeal</i></p>	<p>The Manage Provider Grievance and Appeal business process handles provider appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process. This process supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce</p>	<p>1*</p>	<p>4TG was unable to affirm any of the measures for this business process as no documentation was provided</p>

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>the issues that give rise to grievances and appeals. NOTE: States may define “grievance” and “appeal” differently, depending on state laws. This process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when an application for enrollment is denied.</p>		
<p>Provider Support - Perform Provider Outreach</p>	<p>The Perform Provider Outreach business process originates internally within the Agency in response to multiple activities, e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, changes in the Medicaid program policies and procedures. For Prospective Providers not currently enrolled, provider outreach information is developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers). For Providers currently enrolled, information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives. Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.</p>	<p>1**</p>	<p>4TG was only able to partially affirm the measures for this business process based on the documentation provided. Therefore, the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to: staffing; the accuracy of this business process; outreach and education</p>
<p>1* – indicates that the information in the documentation provided was insufficient to affirm any of the characteristics and/or measures for a process or that no documentation was provided to address the process; therefore the Maturity Level defaulted to a Level 1.</p>			

<b>Business Process – <i>Business Capability</i></b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
1** – indicates that 4TG was only able to partially affirm the measures for this business process based on the documentation provided; therefore the Maturity Level defaulted to a Level 1.			

## Contractor Management

### Business Area and Business Process Description



The Contractor Management business area accommodates States that have managed care contracts or a variety of outsourced contracts. Some States may, for example, group Provider and Contractor in one business area. The Contractor Management business area has a common focus (e.g., manage outsourced contracts), owns and uses a specific set of data (e.g., information about the contractor or the contract), and uses business processes that have a common purpose (e.g., solicitation, procurement, award, monitoring, management, and closeout of a variety of contract types). Creating a separate business area for Contractor Management allows the MITA BPM to highlight this part of the Medicaid enterprise, which is becoming increasingly important to State Medicaid agencies. Indeed, it is the primary focus in some States that have comprehensive managed care or multiple-contractor operations.

In the Contractor Management business area, the many types of healthcare service delivery contracts (e.g., managed care, at-risk mental health or dental care, primary care physician) and the many types of administrative services (e.g., fiscal agent, enrollment broker, Surveillance and Utilization Review [SUR] staff, and third-party recovery) are treated as single business processes because the business process activities are the same, even though the input and output data and the business rules may differ.

## Current Capability Maturity Assessment Results and Gap Analysis

The table below documents the Maturity Levels associated with the current processes within Contractor Management for the Massachusetts Medicaid Enterprise and provides a gap analysis for each business process within the Contractor Management Business area.

In addition to reviewing documentation, 4TG staff was also able to conduct a brief, high-level interview with an EOHHS subject matter expert (SME) concerning the Contractor Management business area, and the overlapping Business Relationship Management capabilities. Because the SME interview was conducted during a limited period of time and at an elevated level, we did not ask the specific questions contained in the measures. As a result, the Gap Analysis results for this area indicate those processes containing measures that could not be answered based on either our high-level interview with the SME or the documentation provided.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - <i>Award Administrative Contract</i>	The Award Administrative Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: contract validation; efficiency; or the quality of this business process.
Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - <i>Close-Out Administrative Contract</i>	The Close-out Administrative Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	1	4TG was able to fully affirm this business process based on the high-level interview with the SME, who confirmed that there is no documented process to close-out a contract at the expiration of the term.
Administrative Contracting (Enrollment Brokers, QRO, FI, FA, etc.) - <i>Manage</i>	The Manage Administrative Contract business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the	1**	4TG was only able to partially affirm the measures for this business process based on the documentation

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
<i>Administrative Contract</i>	contract throughout its duration.		provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: staffing; data access and comparability; contract validation; accuracy and the quality of this business process.
<i>Contractor Information Management - Inquire Contractor Information</i>	The Inquire Contractor Information business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: staffing; accuracy; efficiency and quality of this business process.

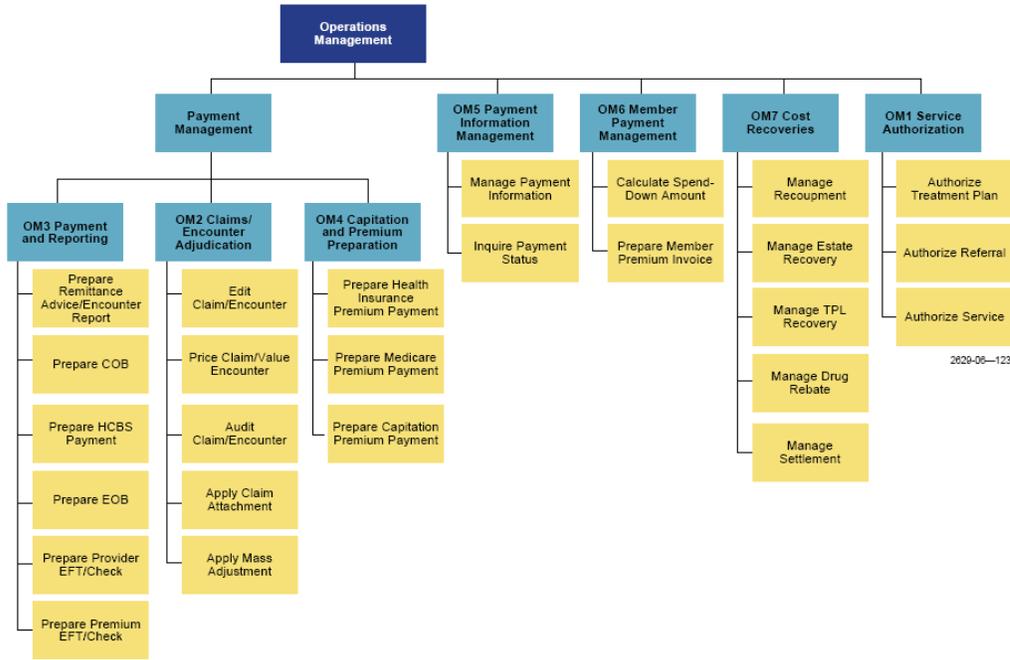
<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Contractor Information Management - <i>Manage Contractor Information</i>	The Manage Contractor Information business process receives a request for addition, deletion, or change to the Contractor Registry; validates the request, applies the instruction, and tracks the activity.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: notification of changes made to users and processes; staffing; accuracy; and quality of this business process.
Contractor Support - <i>Manage Contractor Communication</i>	<p>The Manage Contractor Communication business process receives requests for information, appointments and assistance from contractor such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed and produced for distribution via the Send Outbound Transaction process.</p> <p>NOTE: Inquiries from prospective and current contractors are handled by the Manage Contractor Communication process by providing assistance and responses to individual entities, i.e., bidirectional communication. The Perform Contractor Outreach process targets both prospective and current contractor populations for distribution of information regarding programs, policies and other issues.</p>	1	4TG was able to fully affirm this business process at Maturity Level 1.
Contractor Support - <i>Perform Potential Contractor Outreach</i>	The Perform Potential Contractor Outreach business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures. For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs. For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives. Contractor outreach communications are distributed through various mediums via the Send Outbound	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: timeliness; staffing; outreach targeting; accuracy; and quality of this business process.

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	Transaction. All contractor outreach communications are produced, distributed, tracked, and archived by the agency according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.		
Contractor Support - Support Contractor Grievance and Appeal	The Support Contractor Grievance and Appeal business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Contractor Communications process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are distributed to the contractor information file. The contractor is formally notified of the decision via the Send Outbound Transaction process. This process supports the Program Quality Management business area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. NOTE: States may define “grievance” and “appeal” differently, perhaps because of state laws. *This process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal for example when an application is denied.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to the: accuracy of responses; decision consistency; provider case assistance and communications issues; and quality of this business process.
Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) – Award Health Services Contract	The Award Health Services Contract business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: contract validation and verification; timeliness; staffing; accuracy;

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
			efficiency; and the quality of this business process.
Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) – <i>Close out Health Services Contract</i>	The Close-out Health Services Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	1	4TG was able to fully affirm this business process at Maturity Level 1, based on the high-level interview with the SME, who confirmed that there is no documented process to close-out a contract at the expiration of the term.
Health Services Contracting (PCCM, PCP, MCO, PBM, etc.) – <i>Manage Health Services Contract</i>	The Manage Health Services Contract business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.	1*	4TG was not able to affirm any measures for this business process at Maturity Level 1 because no documentation was provided and the specific measures were not addressed during the high-level SME interview, therefore the Maturity Level defaulted to Level 1.
<p>1* – indicates that the information in the documentation provided was insufficient to affirm any of the characteristics and/or measures for a process or that no documentation was provided to address the process; therefore the Maturity Level defaulted to a Level 1.</p> <p>1** – indicates that 4TG was only able to partially affirm the measures for this business process based on the documentation provided; therefore the Maturity Level defaulted to a Level 1.</p>			

# Operations Management

## Business Area and Business Process Description



The Operations Management business area is the focal point of most State Medicaid enterprises today. It includes operations that support the payment of providers, managed care organizations, other agencies, insurers, and Medicare premiums and support the receipt of payments from other insurers, providers, and member premiums.

This business area focuses on payments and receivables and “owns” all information associated with service payment and receivables. Most States have automated operations that support these payments. In fact, this is probably the part of Medicaid that is most representative of all State Medicaid programs.

Common business processes include validating requests for payment and determining payable amount; responding to premium payment schedules and determining payable amount; and identifying and pursuing recoveries.

## Current Capability Maturity Assessment Results and Gap Analysis

The table below documents the Maturity Levels associated with the current processes within Operations Management for the Massachusetts Medicaid Enterprise and provides a gap analysis for each business process within the Operations Management Business area.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
OM1 - Service Authorization – <i>Authorize Referral</i>	The Authorize Referral business process is used when referrals between providers must be approved for payment. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. Referral authorization usually occurs in certain provider network and managed care settings. Authorize referrals closely follows the details of Authorize Service and may not require a separate business process definition.	2	4TG was able to affirm this business process at a Maturity Level 2. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 3 because the documentation provided did not address any measures related to increased accuracy of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 3.
OM1 - Service Authorization – <i>Authorize Service</i>	The Authorize Service business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, surgeries, tests, drugs, durable medical equipment, and institutional days of stay. It is primarily used in a fee-for-service setting. The pre-approved is a care management function and begins with receiving a referral request data set from an EDI, Paper/Fax, phone, or 278 Health Care Services Review Inbound Transaction Process. Requests are evaluated based on urgency and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state), validating key data, and ensuring that requested referral is appropriate and medically necessary. After review, a referral is approved, modified,	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided.

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>denied or pended for additional information. The appropriate response data set for the outbound 278 Response Transaction, 277 Request for additional information or paper/fax notifications/correspondence is sent to the provider using the Send Outbound Transaction through Manage Provider Communication.</p> <p>A post-approved referral is an editing/auditing function that requires review of referral information after the referral has been made. A review may consist of: verifying referral documentation to ensure a referral for services was appropriate and medically necessary; validating provider type and specialty information to ensure a referral is in line with agency policies and procedures. Post-approved validation typically occurs in the Edit Claims/Encounter or Audit Claims/Encounter processes.</p> <p>NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, Inpatient, Out-of-State Services, and Emergencies.</p>		
OM1 - Service Authorization - <i>Authorize Treatment Plan</i>	<p>The Authorize Treatment Plan business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan. A Treatment Plan prior-authorizes the named providers and services. The individual providers are pre-approved for the service and do not have to submit their own Service Request. It typically covers many services and spans</p>	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>a length of time. A service request is more limited and focuses on a specific visits, services, or products. The pre-approved treatment plan is a care management function and begins with receiving an authorize treatment plan request data set from either an EDI, Paper/Fax, or phone Inbound Transaction Process, evaluating based on urgency and type of service/taxonomy (speech, physical therapy, home health ), validating key data, and ensuring that requested plan of treatment is appropriate and medically necessary. After reviewing; approves, modifies, pends or denies the request and sends the appropriate response data set for the outbound transaction or paper/fax notifications or correspondence from the Manage Provider Communication process or sending a 277 Request for Additional Information to the provider. A post-approved treatment plan is an audit function that reviews pended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.</p>		
<p>OM2 - Claims/Encounter Adjudication - Apply Claim Attachment</p>	<p>This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) from the Edit Claim/Encounter or Audit Claim/Encounter process or has been sent by the provider (unsolicited) from the Receive Inbound Transaction process, linking it with a trace number to associated claim, stapling to a claim or pending the attachment data set for a predetermined time period set by edit and/or audit process rules, validating application level edits, determining if the data set provides the additional information necessary to</p>	<p>2</p>	<p>4TG was able to affirm this business process at a Maturity Level 2. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 3 because the documentation provided did not address any of the measures related to: staffing or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 3.</p>

Business Process – Business Capability	Process Description	Aggregated Capability Maturity Level	Gap Analysis
	<p>adjudicate the claim, and if yes, moving the attachment with claim to the next adjudication process; if no, move to payment processing as a denied claim or trigger a request for additional information, and purging an attachment data set after a predetermined time period set by edit or audit process rules if no claim is found.</p> <p>NOTE: If no claim is found, the attachment data set is pended for a predetermined time period in accordance with state specific business rules. After this time period, the attachment data set is purged.</p>		
<p>OM2 - Claims/Encounter Adjudication - <i>Apply Mass Adjustment</i></p>	<p>The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the claims by claim/bill type or HCPCS, CPT, Revenue Code(s), or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that will reverse the paid claims and repay correctly. This business process often affects multiple providers as well as multiple claims. NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment involves many claims within a range of dates submitted by multiple providers.</p>	<p>1</p>	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.</p>
<p>OM2 - Claims/Encounter Adjudication - <i>Audit Claim/Encounter</i></p>	<p>The Audit Claim/Encounter E2E business process receives a validated original or adjustment claim data set from the Edit Claim/Encounter process and Checks Payment History Repository for duplicate processed claims/encounters and life time limits.</p>	<p>2</p>	<p>4TG was able to affirm this business process at a Maturity Level 2. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 3 because the documentation provided did not address any of the</p>

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity a Suspends data sets that fail audits for internal review, corrections, or additional information Sends successfully audited data sets to the Price Claim/Value Encounter process All claim/encounter types must go through most of the steps within the Audit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This E2E is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter processes.</p>		<p>measures related to staffing, error rate reduction or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 3.</p>
<p>OM2 - Claims/Encounter Adjudication - <i>Edit Claim/Encounter</i></p>	<p>The Edit Claim/Encounter E2E business process receives an original or an adjustment claim/encounter data set from the Receive Inbound Transaction process and- Determines its submission status- Validates edits, service coverage, TPL, coding- Populates the data set with pricing information Sends validated data sets to Audit Claim/Encounter process and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This E2E is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter processes.</p>	<p>2</p>	<p>4TG was able to affirm this business process at a Maturity Level 2. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 3 because the documentation provided did not address any of the measures related to staffing, use of MITA standard interfaces, or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 3.</p>

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>NOTE: The Edit Claim/Encounter process does not apply to:- Point of Sale, which requires that Edit, Audit, and other processes be integrated, or- Direct Data Entry, On-line adjudication, or Web enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data.</p>		
<p>OM2 - Claims/Encounter Adjudication - Price Claim/Value Encounter</p>	<p>The Price Claim/Value Encounter business process begins with receiving a claim/encounter data set from the Audit Claim/Encounter Process, applying pricing algorithms, calculates managed care and PCCM premiums, decrements service review authorizations, calculates and applies member contributions, and provider advances, deducts liens and recoupment. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Repository from the Manage Payment History process and are accessible to all Business Areas. All Claim Types must go through most of the processes and sub-processes but with different logic.</p> <p>NOTE: An adjustment to a claim is an exception use case to this process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the Payment History Repository.</p>	<p>1</p>	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to the level of automation for single claims adjustments of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.</p>
<p>OM3 - Payment and Reporting - Prepare Coordination of Benefits (COB)</p>	<p>The Prepare COB business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. The Prepare COB business process begins with the</p>	<p>2</p>	<p>4TG was able to affirm this business process at a Maturity Level 2. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 3 because the documentation provided did not address any of the measures related to staffing or</p>

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>completion of the Price Claim/Value Encounter process. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria such as error codes and associated disposition, service codes, program codes, third party liability information available from both the original claim and/or eligibility files. This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, formatting of claims data into the outbound EDI data set, validating that the outbound EDI transaction is in the correct format and forwarding to the Send Outbound Transaction.</p>		<p>the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 3.</p>
<p>OM3 - Payment and Reporting - Prepare Explanation of Benefits (EOB)</p>	<p>The Prepare EOB business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs or letters must be provided to the clients within 45 days of payment of claims. This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the Explanation of Benefits (EOBs) and/or notification letters, formatting the data into the required data set, which is sent to the Send Outbound Transaction for generation. The resulting data set is also sent to Manage Applicant and Member Communication. NOTE: This process does not include the handling of returned data nor does it include sending the EOB Sample Data Set.</p>	<p>2</p>	<p>4TG was able to affirm this business process at a Maturity Level 2. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 3 because the documentation provided did not address any of the measures related to the use of MITA standard interfaces, coordination with other agencies in the EOB process, staffing or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 3.</p>

<p>OM3 - Payment and Reporting - <i>Prepare Home and Community-Based Services (HCBS) Payment</i></p>	<p>Many home and community based services are not part of the traditional Medicaid benefit package. Services tend to be client specific and often are arranged through a plan of care. Services for Home &amp; Community Based waivers are often rendered by a-typical providers and may or may not be authorized or adjudicated in the same manner as other health care providers.</p> <p>The Prepare Home and Community-Based Services Payment business process describes the preparation of the payment report data set. These will be sent on paper or electronically to providers and used to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History process for loading into the Payment History Repository. The reimbursement amount is sent to the Manage Provider Information process for loading into the Provider Registry for purposes of accounting and taxes.</p> <p>NOTE: This process does not include sending the home &amp; community based provider payment data set transaction.</p>	<p>1</p>	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to staffing or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.</p>
<p>OM3 - Payment and Reporting - <i>Prepare Premium EFT/Check</i></p>	<p>The Prepare Premium EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including- Calculation of-- HIPP premium based on members' premium payment data in the Contractor Registry-- Medicare premium based on dual eligible members' Medicare premium payment data in the Member Registry-- PCCM management</p>	<p>1</p>	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to increased value to the stakeholders, staffing or the efficiency, accuracy or quality of this business process.</p>

	<p>fee based on PCCM contract data re: difference reimbursement arrangements in the Contractor Registry-- MCO premium payments based on MCO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package in the Contractor Registry-- Stop-loss claims payments for MCO's in the Contractor Registry- Application of automated or user defined adjustments based on contract, e.g., adjustments or performance incentives- Disbursement of premium, PCCM fee, or stop loss payment from appropriate funding sources per Agency Accounting and Budget Area rules- Associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the Premium Payment within the banking system may not be HIPAA covered entities]- Routing the payment per the Contractor Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction- Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid premium, fees, and stop loss claims transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history Support frequency of payments under the federal Cash Management Improvement Act (CMA), including real time payments where appropriate.</p>		<p>This information could be used to potentially affirm this process fully at a Maturity Level 2.</p>
<p>OM3 - Payment and Reporting - Prepare Provider EFT/Check</p>	<p>The Prepare Provider EFT/Check business process is responsible for managing the generation of electronic and paper based</p>	<p>1</p>	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the</p>

	<p>reimbursement instruments, including:</p> <ul style="list-style-type: none"> <li>- Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, HCBS provider claims, and MCO encounters based on inputs such as the priced claim, including any TPL, crossover or member payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and taxes, performance incentives, recoupment, garnishments, and liens per data in the Provider Registry, Agency Accounting and Budget Area rules, including the Manage 1099 process</li> <li>- Payroll processing, e.g., for HCBS providers, includes withholding payments for payroll, federal and state taxes, as well as union dues</li> <li>- Disbursement of payment from appropriate funding sources per Agency Accounting and Budget Area rules</li> <li>- Associating the EFT with a X12 835 electronic remittance advice transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities</li> <li>- Routing the payment per the Provider Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction</li> <li>- Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history</li> <li>- Support frequency of payments</li> </ul>		<p>characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to increased timeliness, whether increased automation allows the agency to focus on cost management, staffing or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.</p>
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	under the federal Cash Management Improvement Act (CMA), including real time payments where appropriate, e.g., Pharmacy POS.		
OM3 - Payment and Reporting - <i>Prepare Remittance Advice/Encounter Report</i>	The Prepare Remittance Advice/Encounter Report business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the pricing, audit and edit processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading. NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.	1	4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to staffing for this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.
OM4 - Capitation and Premium Preparation - <i>Prepare Capitation Premium Payment</i>	The Prepare Capitation Premium Payment business process includes premiums for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the Maintain Member Information, retrieving the rate data associated with the plan from the Manage Provider Information, formatting the payment data into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Manage Provider Information for updating.  This process does not include sending the capitation payment data set.	1	4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to increased value to stakeholders, whether increased automation allows the agency to focus on cost management, staffing or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.

<p>OM4 - Capitation and Premium Preparation - Prepare Health Insurance Premium Payment</p>	<p>Medicaid agencies are required to pay the private health insurance premiums for members who may have private health insurance benefits through their employers and because of devastating illness are no longer employable and become Medicaid eligible. It can also include children who are Medicaid eligible but also have private health insurance provided by a parent(s). In these circumstances, a cost effective determination is made and a premium is prepared and sent to the member's private health insurance company rather than enrolling them into a Medicaid managed health care plan or pay fee for service claims as submitted by providers. The Process Health Insurance Premium Payments business process begins by receiving eligibility information via referrals from Home and Community Services Offices, schools, community services organizations, or phone calls directly from members; checking for internal eligibility status as well as eligibility with other payers, editing required fields, producing a report, and notifying members. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. The formatted premium payment data set is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Maintain Member Information for updating. NOTE: This process does not include sending the health insurance premium payment data set.</p>	<p>1**</p>	<p>4TG was only able to partially affirm the measures for this business process based on the documentation provided. Therefore, the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to: transaction standards, manual processes, enrollment of members in health insurance, premium payments and whether the process is siloed and specific to the agency.</p>
<p>OM4 – Capitation and Premium Preparation - Prepare Medicare Premium Payment</p>	<p>State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration</p>	<p>2</p>	<p>4TG was able to affirm this business process at a Maturity Level 2. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 3 because the documentation provided did not address any of the</p>

	<p>(SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance.</p> <p>The Prepare Medicare Premium Payments business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Payment History and Manage Member Information for loading.</p> <p>NOTE: This process does not include sending the Medicare premium payments EDI transaction.</p>		<p>measures related to the use of MITA standard interfaces, the use of national standards, staffing or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 3.</p>
<p>OM5 - Payment Information Management - <i>Inquire Payment Status</i></p>	<p>The Inquire Payment Status business process begins with receiving a 276 Claim Status Inquiry or via paper, phone, fax or AVR request for the current status of a specified claim(s), calling the payment history data store and/or repository, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response, and sending claim status response data set via the Send Outbound Transaction process.</p>	1	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to increased value to stakeholders, whether increased automation allows the agency to focus on cost management, staffing or the programmatic and cost efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.</p>
<p>OM5 - Payment Information Management - <i>Manage Payment Information</i></p>	<p>The Manage Payment Information business process is responsible for managing all the operational aspects of the Payment Information Repository, which is the source of</p>	1	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher</p>

	<p>comprehensive information about payments made to and by the state Medicaid agency for healthcare services. The Payment Information Repository exchanges data with Operations Management business processes that generate payment information at various points in their workflow. These processes send requests to the Payment Information Repository to add, delete, or change data in payment records. The Payment Information Repository validates data upload requests, applies instructions, and tracks activity. In addition to Operations Management business processes, the Payment Information Repository provides access to payment records to other Business Area applications and users, such as the Manage Program, Member, Contractor, and Provider Information processes, via record transfers, response to queries, and “publish and subscribe” services.</p>		<p>Maturity Level 2 because the documentation provided did not address the measures related to increased value to stakeholders, whether increased automation allows the agency to focus on cost management, staffing or the programmatic and cost efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.</p>
<p>OM6 - Member Payment Management - Calculate Spend-Down Amount</p>	<p>A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called “spend-down” (see Determine Eligibility). The Calculate Spend-Down Amount business process describes the process by which spend-down amounts are tracked and a client’s responsibility is met through the submission of medical claims. Excess resources are automatically accounted for during the claims processing process resulting in a change of eligibility status once spend down has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations. The Calculate Spend-Down Amount business process begins with the receipt of member eligibility data. Once</p>	<p>1*</p>	<p>4TG was unable to affirm any of the measures for this business process as no documentation was provided</p>

	<p>the eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services. NOTE: The 'Calculate Spend-down Amount' today is primarily a manual process in the Eligibility Determination, Member Payment Management and Maintain Payment History threads. At Level 3 these processes have almost eliminated any use of manual intervention.</p>		
<p>OM6 - Member Payment Management - Prepare Member Premium Invoice</p>	<p>Due to tightening budgets and an ever-increasing population that is covered under the Medicaid umbrella, States began client/member cost-sharing through the collection of premiums for medical coverage. The premium amounts are based on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment.</p> <p>The Prepare Member Premium Invoice business process begins with a timetable (usually monthly) for scheduled invoicing. The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Maintain Member Information process for updating.</p> <p>NOTE: This process does not include sending the member premium invoice EDI transaction.</p>	<p>1*</p>	<p>4TG was unable to affirm any of the measures for this business process as no documentation was provided</p>
<p>OM7 - Cost Recoveries - Manage Drug Rebate</p>	<p>The Manage Drug Rebate business process describes the</p>	<p>1**</p>	<p>4TG was only able to partially affirm the measures for this</p>

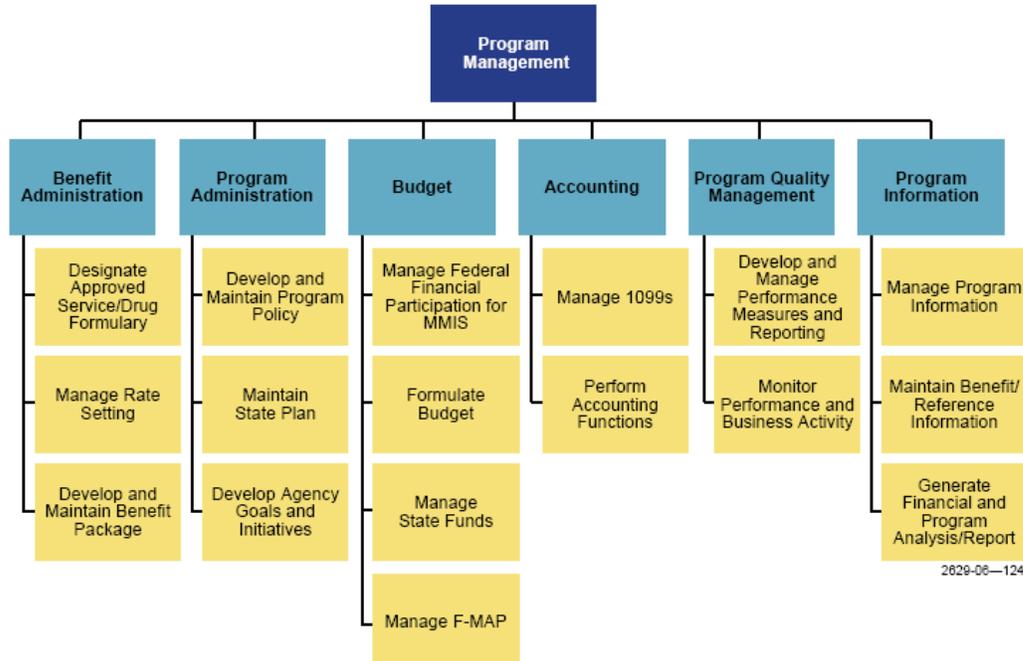
	<p>process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes receiving quarterly drug rebate data from CMS, comparing it to quarterly payment history data, identifying drug data matches based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the Send Outbound Transaction Process sending to Perform Accounting Functions.</p>		<p>business process based on the documentation provided. Therefore, the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to: the use of paper invoices, the manual validation of rebates, the timeliness and accuracy of the data, whether the use of non-standard data and formats impacts the analysis and reporting for this process, the manual nature and labor intensity of the process, the cost effectiveness and impact of this process on stakeholders.</p>
<p>OM7 - Cost Recoveries - <i>Manage Estate Recovery</i></p>	<p>Estate recovery is a process whereby States are required to recover certain Medicaid benefits correctly paid on behalf of an individual. This is done by the filing of liens against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, ICF/ID, or other medical institution.</p> <p>The Manage Estate Recovery business process begins by receiving estate recovery data from multiple sources (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), generating correspondence data set (e.g., demand of notice to probate court via Send Outbound Transaction process, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the Manage Applicant and Member Communication process, opening formal estate recovery case based on estate ownership and</p>	<p>1</p>	<p>4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided did not address the measures related to staffing for this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2</p>

	<p>value of property, determining value of estate lien, files petition for lien, files estate claim of lien, conducts case follow-up, sending data set to Perform Accounting Functions, releasing the estate lien when recovery is completed, updating Member Registry, and sending to Manage Payment History for loading.</p> <p>NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.</p>		
<p>OM7 - Cost Recoveries - <i>Manage Recoupment</i></p>	<p>The Manage Recoupment business process describes the process of managing provider recoupment. Provider recoupment are initiated by the discovery of an overpayment as the result of a provider utilization review audit, receipt of a claims adjustment request, for situations where monies are owed to the agency due to fraud/abuse, and the involvement of a third party payer. The E2E business thread begins with discovering the overpayment, retrieving claims payment data from the Manage Claims History, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results from the Manage Provider Communication, applying refund in the system from the Perform Accounting Functions, and monitoring payment history until the repayment is satisfied. Recoupments can be collected via check sent by the provider or credited against future payments for services.</p>	2	<p>4TG was able to affirm this business process at a Maturity Level 2. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 3 because the documentation provided did not address the measures related to the use of MITA standard interfaces, increased stakeholder satisfaction, staffing or the efficiency, accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 3.</p>
<p>OM7 - Cost Recoveries - <i>Manage Settlement</i></p>	<p>The Manage Settlement business process begins with requesting annual claims summary data from Manage Payment History, reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the</p>	1*	<p>4TG was unable to affirm any of the measures for this business process as no documentation was provided</p>

	necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates, sending the cost settlement data set via the Send Outbound Transaction process to Manage Provider Communication, Manage Payment History, Manage Rate Setting and sending receivables data to Perform Accounting Functions, and tracking settlement payments.		
OM7 - Cost Recoveries - <i>Manage TPL Recovery</i>	The Manage TPL Recoveries business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, Attorney's, SUR, Fraud and Abuse units, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from Manage Payment History, creating post-payment recovery files, sending notification data to other payer or provider from the Manage Provider Communication process, receiving payment from provider or third party payer, sending receivable data to Perform Accounting Function, and updating payment history Manage Payment History. NOTE: States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase method.	1	4TG was able to affirm this business process at a Maturity Level 1. However, 4TG was unable to fully affirm all of the characteristics and/or measures at the higher Maturity Level 2 because the documentation provided by EOHHS did not address the measures related to cost efficiency, whether increased automation allows the agency to focus on cost management, the accuracy or quality of this business process. This information could be used to potentially affirm this process fully at a Maturity Level 2.
1* – indicates that the information in the documentation provided was insufficient to affirm any of the characteristics and/or measures for a process or that no documentation was provided to address the process; therefore the Maturity Level defaulted to a Level 1			

## Program Management

### Business Area and Business Process Description



The Program Management business area houses the strategic planning, policy making, monitoring, and oversight activities of the agency. These activities depend heavily on access to timely and accurate data and the use of analytical tools. This business area uses a specific set of data (e.g., information about the benefit plans covered, services rendered, expenditures, performance outcomes, and goals and objectives) and contains business processes that have a common purpose (e.g., managing the Medicaid program to achieve the agency's goals and objectives such as by meeting budget objectives, improving customer satisfaction, and improving quality and health outcomes).

This business area includes a wide range of planning, analysis, and decision-making activities, including benefit plan design, rate setting, healthcare outcome targets, and cost-management decisions. It also contains budget analysis, accounting, quality assessment, performance analysis, outcome analysis, continuity of operations plan, and information management.

This is the heart of the Medicaid enterprise and the control center for all operations. As the Medicaid enterprise matures, Program Management benefits from immediate access to information, addition of clinical records, use of standards, and interoperability with other programs. The Medicaid program is moving from a focus on daily operations (e.g., number of claims paid) to a strategic focus on how to meet the needs of the population within a prescribed budget.

## Current Capability Maturity Assessment Results and Gap Analysis

The table below documents the Maturity Levels associated with the current processes within Program Management for the Massachusetts Medicaid Enterprise and provides a gap analysis for each business process within the Program Management Business area.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Accounting - Manage 1099s	The Manage 1099s business process describes the process by which 1099s are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number. The Manage 1099s process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Manage Settlements process. The Manage 1099s process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the Send Outbound Transaction process. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Accounting - Perform Accounting Functions	The Perform Accounting Functions business process receives information from payment processes such as Prepare Provider EFT/Check, Prepare Premium EFT/Check and Prepare Member Premium Invoice. It also receives information financial recovery processes such as Manage Recoupment, Manage TPL Recovery, Manage Estate Recovery and Manage Drug Rebate. Currently States use a	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	variety of solutions including outsourcing to another Department or use of a COTS package.		
Benefit Administration - <i>Designate Approved Services/Drug Formulary</i>	The Designate Approved Services/Drug Formulary business process begins with a review of new and/or modified service codes or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package. Service, supply and drug codes are reviewed by a team of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and state plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes. NOTE: This does not include implementation of Approved Service/Formulary.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Benefit Administration - <i>Develop and Maintain Benefit Package</i>	The Develop & Maintain Benefit Package business process begins with receipt of coverage requirements and recommendations through new or revised: Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations or changes resulting from court decisions.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	<p>Benefit package requirements are mandated through regulations or other legal channels and must be implemented. Implementation of benefit package recommendations is optional and these requests must be approved, denied or modified. Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including:</p> <ul style="list-style-type: none"> <li>- Determination of scope of coverage</li> <li>- Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc.</li> <li>- Identification of impacted members and trading partners.</li> </ul>		
Benefit Administration - <i>Manage Rate Setting</i>	The Established Rate Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Budget - <i>Formulate Budget</i>	The Formulate Budget business process examines the current budget, revenue stream and trends, and expenditures, assesses external factors affecting the program, assesses agency initiatives and plans, models different budget scenarios, and periodically produces a new budget.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Budget - <i>Manage Federal Financial Participation for MMIS</i>	The Federal government allows funding for the design, development, maintenance and operation of a federally certified MMIS. The Manage Federal Financial Participation business process oversees reporting and monitoring of Advanced Planning Documents and other program documents necessary to secure and maintain federal financial participation. These are the	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	types of functions within this business area but this does not appear to be a stand-alone process.		
Budget - <i>Manage Federal Medical Assistance Percentages (F-MAP)</i>	The Manage F-MAP business process periodically assesses current F-MAP for benefits and administrative services to determine compliance with federal regulations and state objectives.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Budget - <i>Manage State Funds</i>	The Manage State Funds business process oversees Medicaid state funds and ensures accuracy in reporting of funding sources. Funding sources for Medicaid services may come from a variety of sources and often State funds are spread across administrations. The Manage State Funds monitors state funds through ongoing tracking and reporting of expenditures. These are the types of functions that may occur within this business area, but this does not appear to be a stand-alone process.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Program Administration - <i>Develop Agency Goals and Initiatives</i>	The Develop Agency Goals and Initiatives business process periodically assess current mission statement, goals, and objectives to determine if changes are called for. Changes to goals and objectives could be warranted under a new administration or in response to changes in demographics or public opinion; or in response to natural disasters such as Katrina.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Program Administration - <i>Develop and Maintain Program Policy</i>	The Develop and Program Administrative Policy Business Process responds to requests or needs for change in the agency's programs, benefits, or rules, based on federal or state statutes and regulations; governing board or commission directives; QIO findings; federal or state audits; agency decisions; and consumer	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	pressure.		
Program Administration - <i>Maintain State Plan</i>	The Maintain State Plan business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Program Information - <i>Generate Financial &amp; Program Analysis/Report</i>	It is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established are meeting the needs of the member population and are performing according to the intent of the legislative laws or Federal reporting requirements. The Generate Financial & Program Analysis/Report process begins with a request for information or a time table for scheduled correspondence. The process includes defining the required reports format, content, frequency and media, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy), retrieving data from multiple sources, e.g., Manage Payment History; Maintain Member Information; Manage Provider Information; and Maintain Benefits/Reference Repository; compiling the retrieved data, compiling the data, and formatting into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction. NOTE: This process does not include maintaining the benefits, reference, or program information. Maintenance of the benefits and reference information is covered under a separate business process.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Program Information -	The Maintain	1*	4TG was unable to affirm any of

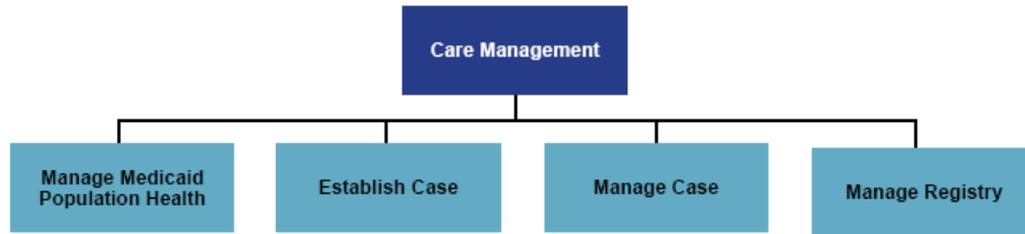
<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
<i>Maintain Benefit/Reference Information</i>	Benefits/Reference Information process is triggered by any addition or adjustment that is referenced or used during the Edit Claim/Encounter, Audit Claim/Encounter or Price Claim/Encounter. It can also be triggered by the addition of a new program or the change to an existing program due to the passage of new state or federal legislation, or budgetary changes. The process includes adding new HCPCS, CPT and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the Manage Prospective & Current Member Communication, updating/adding provider information from the Manage Provider Information, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the Receive Inbound Transaction.		the measures for this business process as no documentation was provided
<i>Program Information - Manage Program Information</i>	The Manage Program Information business process is responsible for managing all the operational aspects of the Program Information Repository, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information Repository receives requests to add, delete, or change data in program records. The Repository validates data upload requests, applies instructions, and tracks activity. The Program	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	Information Repository provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, via batch record transfers, response to queries, and “publish and subscribe” services.		
Program Quality Management - <i>Develop and Manage Performance Measures and Reporting</i>	The Develop and Manage Performance Measures and Reporting business process oversees reporting and monitoring of Medicaid Enterprise to assure that the program meets the statutory requirements of the program. Performance Measures and Reporting requirements are continually assessed and respond to changes in the agency’s programs, benefits, or rules, based on federal or state statutes and regulations; governing board or commission directives; QIO findings; federal or state audits; agency decisions; and consumer pressure.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Program Quality Management - <i>Monitor Performance and Business Activity</i>	The Monitor Performance and Business Activity business process utilizes the performance measures from the Develop and Manage Performance and Reporting business process to oversee efficacy of the Medicaid Enterprise. For example, this process provides the indicators of underserved populations to support member outreach activities and ensures that applicants and members receive the information they need. This process may send prompts to the provider or contractor processes to reevaluate enrollment, to disenroll a provider or contractor to or oversee the outreach activities. This process also detects utilization outliers	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	and alerts applicable claims processes.		
<p>1* – indicates that the information in the documentation provided was insufficient to affirm any of the characteristics and/or measures for a process or that no documentation was provided to address the process; therefore the Maturity Level defaulted to a Level 1</p>			

## Care Management

### Business Area and Business Process Description



*The Care Management business area illustrates the growing importance of care management as the Medicaid program evolves. Care Management collects information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. It also contains business processes that have a common purpose (e.g., identify clients with special needs, assess needs, develop treatment plan, monitor and manage the plan, and report outcomes). This business area includes processes that support individual care management and population management. Population management targets groups of individuals with similar characteristics and needs and promotes health education and awareness.*

*Care Management includes Disease Management; Catastrophic Case Management; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Population Management; Patient Self-Directed Care Management; Immunization and other registries; Waiver Program Case Management; and programs yet to come. With individual patient and case manager access to clinical data and treatment history, Care Management evolves and increases in importance in the Medicaid enterprise.*

## Current Capability Maturity Assessment Results and Gap Analysis

The table below documents the Maturity Levels associated with the current processes within Care Management for the Massachusetts Medicaid Enterprise and provides a gap analysis for each business process within the Care Management Business area.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Establish Case	The Establish Case business process uses criteria and rules to identify target member populations for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication. Cases may be established for:- Medicaid Waiver program case management-- Home and Community-Based Services-- Other- Disease management- Catastrophic cases- EPSDT- Population management Each case type is driven by different criteria and rules, different relationships, and different data.	1**	4TG was only able to partially affirm the measures for this business process 1 based on the documentation provided, therefore the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to the accuracy of member contact information.
Manage Case	The Manage Case Business processes collect information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. Case managers administer, monitor and manage member services.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Manage Medicaid Population Health	These business process designs and implements strategies to improve general population health by targeting individuals by cultural or diagnostic or other demographic indicators. The inputs to this process are census, vital statistics, immigration, and other data sources. The outputs are educational materials, communications, and other media. .	1**	4TG was only able to affirm one measure for this business process based on the documentation provided, therefore the Maturity Level defaulted to a Level 1. The Maturity Level 1 measures unable to be affirmed are related to the: production and use of health education and outreach materials; effectiveness of outreach efforts and population targeting processes; timeliness; access to enrollment records; staffing; or the efficiency, accuracy or quality of this business process.
Manage Registry	This business process operates a registry (e.g. immunizations, cancer), receives continuous updates, responds to inquiries, and provides access to authorized parties.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided.
<p>1* – indicates that the information in the documentation provided was insufficient to affirm any of the characteristics and/or measures for a process or that no documentation was provided to address the process; therefore the Maturity Level defaulted to a Level 1.</p> <p>1** – indicates that 4TG was only able to partially affirm the measures for this business process based on the documentation provided; therefore the Maturity Level defaulted to a Level 1.</p>			

## Program Integrity Management

### Business Area and Business Process Description



*The Program Integrity business area incorporates those business activities that focus on program compliance (e.g., auditing and tracking medical necessity and appropriateness of care and quality of care, fraud and abuse, erroneous payments, and administrative abuses).*

*Program Integrity collects information about an individual provider or member (e.g., demographics; information about the case itself such as case manager ID, dates, actions, and status; and information about parties associated with the case).*

*The business processes in this business area have a common purpose (e.g., to identify case, gather information, verify information, develop case, report on findings, make referrals, and resolve case). As with the previous business areas, a single business process may cover several types of cases. The input, output, shared data, and the business rules may differ by type of case, but the business process activities remain the same.*

*This business area will mature with access to clinical data that improve the capability for identifying real cases of program abuse. Today this business area concentrates on SUR activities, fraud detection, and other types of program safeguards. Although Program Integrity activities continue to have a place as core business processes mature, their focus is predicted to shift from retrospective analysis to prospective and concurrent application of business rules.*

## Current Capability Maturity Assessment Results and Gap Analysis

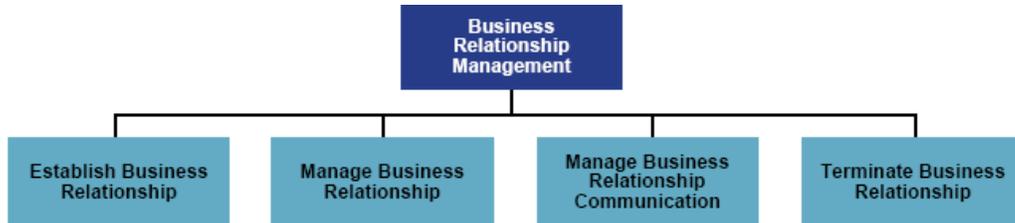
The table below documents the Maturity Levels associated with the current processes within Program Integrity Management for the Massachusetts Medicaid Enterprise and provides a gap analysis for each business process within the Program Integrity Management Business area.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Identify Candidate Case	The Identify Candidate Case business process uses State specific criteria and rules to identify target populations (e.g., providers, contractors, or beneficiaries), establishes patterns or parameters of acceptable/unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Candidate cases may be identified for:- Provider utilization review- Contractor-Beneficiary utilization review- Potential fraud- Drug utilization review- Quality review. Each type of case is driven by different State criteria and rules, different relationships, and different data.	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided
Manage Case	The Manage Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, or beneficiary from the Medicaid program; or the case may be terminated or suspended. Individual State policy determines what evidence is needed to support different types of cases:- Provider utilization review- Provider compliance review- Contractor utilization review- Contractor compliance review- Beneficiary utilization review- Investigation of potential fraud- Drug utilization review- Quality review- Performance review. Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external	1*	4TG was unable to affirm any of the measures for this business process as no documentation was provided

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	investigation.		
<p>1* – indicates that the information in the documentation provided was insufficient to affirm any of the characteristics and/or measures for a process or that no documentation was provided to address the process; therefore the Maturity Level defaulted to a Level 1.</p>			

## Business Relationship Management

### Business Area and Business Process Description



*The Business Relationship Management (BRM) area focuses on the ever-increasing importance of effective communication, collaboration and coordination of the essential Medicaid enterprise business relationships between in-State agencies and inter-State and Federal agencies. This business area includes the standards to enable interoperability across the many areas of the Medicaid Enterprise and also owns the standards for interoperability between the various Enterprise areas and their business partners. BRM contains business processes that have a common purpose to: establish the interagency service agreement; identify the types of information to be exchanged; identify security and privacy requirements; define communication protocols; and, oversee the transfer of information.*

*In most State Medicaid Agencies, data exchange and intra-agency service agreements are commonplace. Secure technological interfaces allow Medicaid Enterprises to send and receive information from in-State sister divisions or agencies, as well as from other inter-State or Federal data-sharing partners. Data exchanged between State Medicaid agencies and other agencies and States is primarily processed manually, meaning that requests are received and responded to in an ad hoc manner.*

*The growing emphasis on Health Information Technology and Exchange is creating an environment where health information exchange is recognized as crucial to improving health outcomes, care delivery and overall population health. The national Standards Harmonization and Product Certification efforts are creating the means for interoperability within States and across the nation, through private and secure infrastructures that can be tailored to State and local business agreements. The BRM processes focus on defining a progressive path for improvement of capability maturity to support the cornerstones of the Value Driven Health Care Framework consisting of (1) Interoperable Electronic Health Records, (2) Quality Benchmarks and Transparency, (3) Price (Episode of Care) Benchmarks and Transparency and (4) Incentives for Provider Performance.*

## Current Capability Maturity Assessment Results and Gap Analysis

The table below documents the Maturity Levels associated with the current processes within Business Relationship Management for the Massachusetts Medicaid Enterprise and provides a gap analysis for each business process within the Business Relationship Management Business area.

In addition to reviewing documentation, 4TG staff was also able to conduct a brief, high-level interview with an EOHHS SME concerning the Contractor Management business area, and the overlapping Business Relationship Management capabilities. Because the SME interview was conducted during a limited period of time and at an elevated level, we did not ask the specific questions contained in the measures. As a result, the Gap Analysis results for this area indicate those processes containing measures that could not be answered based on either our high-level interview with the SME or the documentation provided.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Establish Business Relationship	The Establish Business Relationship business process encompasses activities undertaken by the State Medicaid agency to enter into business partner relationships with other stakeholders. These include Memoranda of Understanding (MOU) with other agencies, electronic data interchange agreements with providers, managed care organizations and other partners, CMS and other Federal agencies, as well as Health Information Exchanges and Regional Health Information Organizations.	1**	4TG was only able to partially affirm the measures for this business process 1 based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: application validation; timeliness; staffing; efficiency; accuracy and the quality of this business process.
Manage Business Relationship	The Manage Business Relationship business process maintains the agreement between the State Medicaid agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The measures unable to be affirmed are related to: staffing; timeliness; data access; efficiency; accuracy and the quality of this business process.
Manage Business Relationship Communication	The Manage Business Relationship Communication business process produces routine and ad hoc	1**	4TG was only able to partially affirm the measures for this business process based on the

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
	communications between the business partners.		documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: the impact of communications on stakeholders; targeting Business Partners; timeliness; staffing; efficiency; accuracy; and the quality of this business process.

<b>Business Process – Business Capability</b>	<b>Process Description</b>	<b>Aggregated Capability Maturity Level</b>	<b>Gap Analysis</b>
Terminate Business Relationship	The Terminate Business Relationship business process cancels the agreement between the State Medicaid agency and the business partner.	1**	4TG was only able to partially affirm the measures for this business process based on the documentation provided and the high-level SME interview, therefore the Maturity Level defaulted to Level 1. The Maturity Level 1 measures unable to be affirmed are related to: data formats; timeliness; staffing; efficiency; and the quality of this business process.
1** – indicates that 4TG was only able to partially affirm the measures for this business process based on the documentation provided; therefore the Maturity Level defaulted to a Level 1.			

# MITA Technical Capability Gap Analysis Findings

## Methodology

The gap analysis for the technical capability matrix (TCM) is inherently different from that for the business capability matrix (BCM). As noted throughout Section 3, the BCM contains overall definitions for each process within each area. For instance, the Business Relationship Area contains the process Manage Business Relationship Communication which has the following description, “The Manage Business Relationship Communication business process produces routine and ad hoc communications between the business partners.” As the Maturity Level of this process increases over time, the process evolves in a predictable fashion which shows an increase in efficiency, the use of data standards, interoperability, etc.

The TCM, however, is not as straightforward. Technical areas are not as defined in the MITA Framework 2.0 as the business processes are in the BCM. Instead, the principles and goals of each technical area are outlined with corresponding definitions of approaches and anticipated technologies. For instance, the technical area of Interoperability is based on the concept of “system to system” communication in the MITA Framework 2.0. The definition of this area can be expounded on to state that the area of Interoperability promotes organized and efficient system to system communication. The more interoperable a system becomes, the more agile and responsive it becomes to system changes.

At first glance, it would seem the characterization for this technical area is robust enough to proceed with a gap analysis in the same manner as the BCM. There are, however, three points to consider.

1. The sub-technical areas which fall within the principle of interoperability are not clearly defined in the MITA Framework 2.0. This becomes clearer, for example, after looking at the Standards Based Data Exchange sub-technical area. This area’s definition depends on MITA data standards which are still being developed.
2. The characterizations for each technical area do not relate to a set of business activities performed by the system in question as in the case of a defined business process. Instead, each area refers to technological concepts that enable a business process to be completed more efficiently.
3. The defined characteristics and measures enable the BCM gap analysis to be completed in a more consistent manner. The TCM, however, does not have any defined characteristics or measures within the MITA Framework 2.0. This results in a more loose form of gap analysis for each area in the TCM when compared with the BCM.

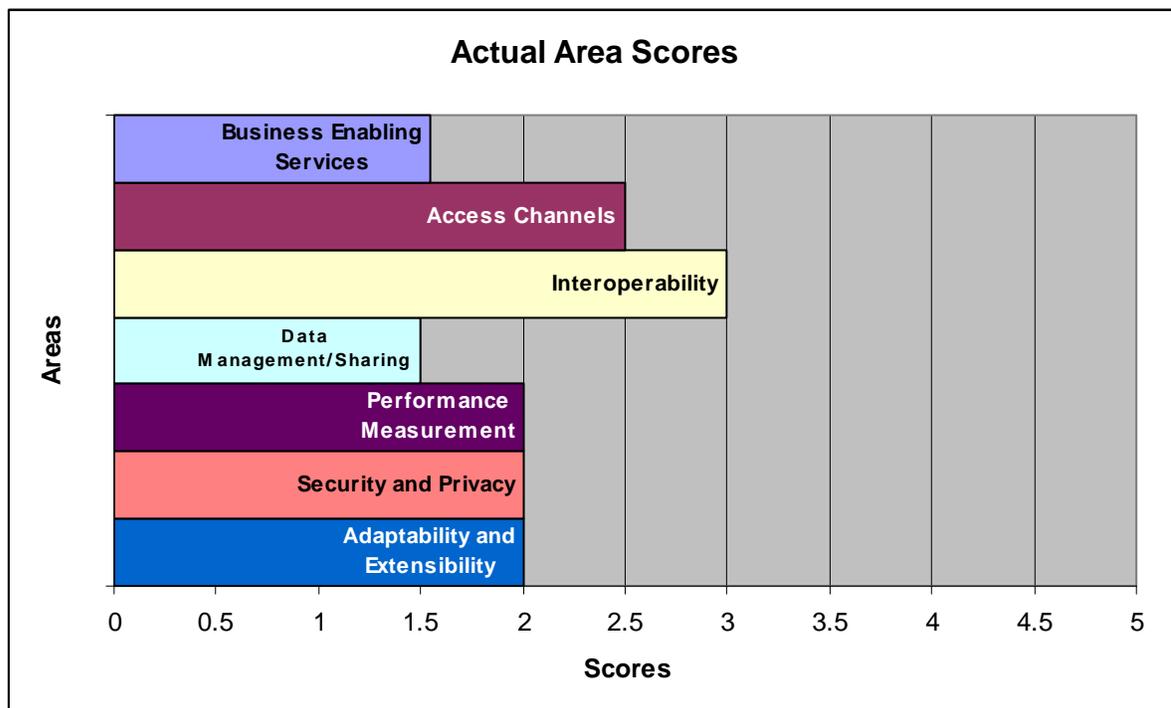
For these reasons, the TCM gap analysis is organized slightly differently than the BCM gap analysis. In the first section, 4TG presents three graphs: The Actual Area Scores Graph, the Highest Possible Area Scores Graph, and the Optimal Scores Overlaid with

Actual Scores Graph in respective order. The second section is broken down into each high level area. Each high level area section begins with a brief description of the area as defined in the MITA Framework 2.0 followed by a table which breaks the high level area down into its sub-technical areas with their respective gap analysis. For reference, located in Appendix B, there is the Lack of Definitions and Documentations table which represents a combination of the above information while also showing those technical areas which lacked the necessary documentation for 4TG to complete the assessment.

## Score Graphs

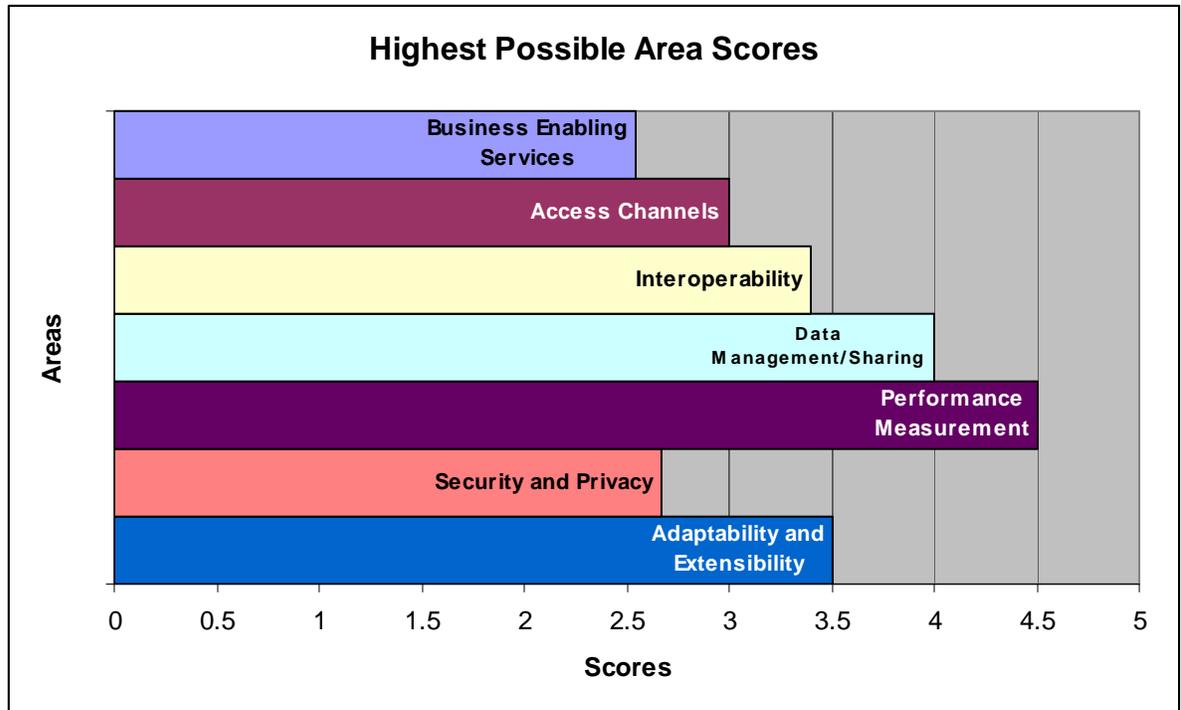
### Actual Area Scores

The intended purpose of the *Actual Area Scores Graph* is to outline the scores assessed by the NewMMIS in a simple graphical format for comparison purposes between each area. By seeing the scores in this fashion, it is easier to ascertain the system's weaker points based upon the documentation provided. This graph will also be used in combination with the *Highest Possible Scores Graph* to show a clear representation of the true gaps between what has been attained in the NewMMIS and what has been defined in the MITA Framework 2.0.



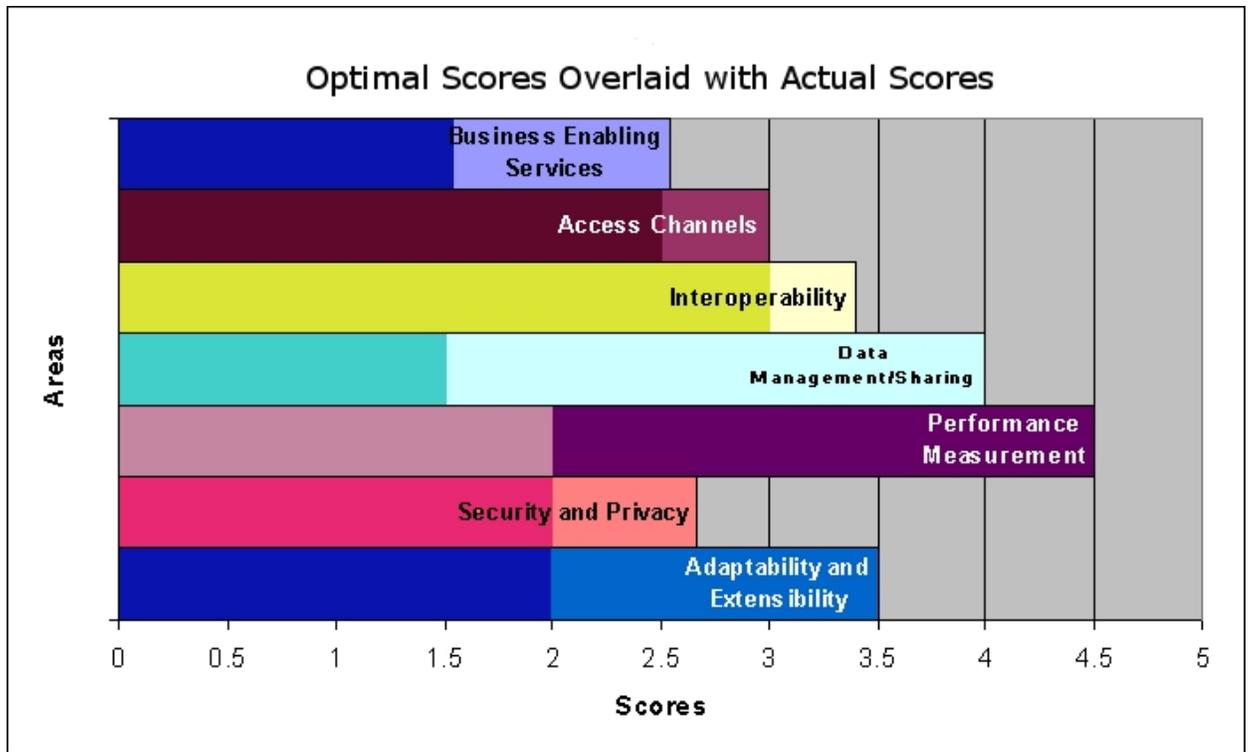
### Highest Possible Scores

The *Highest Possible Scores Graph* is important because it outlines the best possible scores a system can achieve using the current incarnation of the TCM in the MITA Framework 2.0. This graphical clearly shows that even best system could not achieve a level of 4 or higher given the defined technology in the TCM. This should also serve as a reminder that the current TCM will be evolving in the future and that each system should possess the necessary agility to respond to the introduction of new technologies going forward.



### Optimal Scores versus Actual Scores

The *Optimal Scores Overlaid with Actual Scores Graph* puts the previous two pieces together to reveal the assessed gaps in a fully aligned MITA system. Each area is represented by a bar with two shades of color. The left shaded side of the bar represents that areas actual achieved score. The remaining right shaded side of the bar represents the gap between the actual assessed score and the highest possible score give the current state of the TCM.



## Technical Area Gap Analysis

### Business Enabling Services

The Business Enabling Services technical area promotes the dissemination of information and consistent workflow throughout the system in an efficient manner. This technical area can be broken down into 6 sub-technical areas: Forms Management, Workflow Management, Business Process Management, Foreign Language Support, and Decision Support. The latter sub-technical area, Decision Support, can be broken down into 6 further sub-technical areas: Data Warehouse, Data Marts, Ad Hoc Reporting, Data Mining, Statistical Analysis, and Neural Network Tools. The assessment of these technical areas is listed below.

Business Enabling Services			
Technical Area	Level	MITA 2.0 Description	Gap Analysis
Forms Management	2	Online data entry on electronic forms	The highest defined Maturity Level has been attained.

<b>Business Enabling Services</b>			
<b>Technical Area</b>	<b>Level</b>	<b>MITA 2.0 Description</b>	<b>Gap Analysis</b>
Workflow Management	2	Electronic routing of files to business processes and individuals involved in processing. Responsible for processing completion and other individual and business processes	The highest defined Maturity Level has been attained.
Business Process Management	3	Specification and management of business processes in conformance with MITA BPM standards (e.g., Business Process Execution Language [BPEL])	The highest defined Maturity Level has been attained.
Business Relationship Management	1	Manual (e.g., by attaching annotations to case files)	The NewMMIS technical documentation provided does not support the conclusion that the system can track relationships between Medicaid system users and the services they have requested and received.
Foreign Language Support	1	Manual translation of messages into supported foreign languages	The documentation provided states the system does not have the Level 3 ability to have real time translations. Therefore, even though there is a gap in the desired functionality, there is not a gap in the documentation required for completing the TCM.
Decision Support	1	High Level Technical Area encompassing the six DS Sub-Technical Areas below	High Level Technical Area, read below for more information about Gaps in this area.

Business Enabling Services			
Technical Area	Level	MITA 2.0 Description	Gap Analysis
DS: Data Warehouse	1	Undefined	The NewMMIS will be Extracting, transforming, and loading (ETL) data from multiple databases into a data warehouse. This partially meets the criteria for the only defined Level (3) of this area. However, the MITA data standards are not fully developed. Therefore, this area must remain undefined. Technically, there is no gap.
DS: Data Marts	1	Level 1 and 2 have not been defined.	There is no documentation provided supporting the conclusion that data marts will be used in the capacity defined in Level 3 (the only defined level) while meeting MITA data standards which have also not been fully defined.
DS: Ad Hoc Reporting	2	Ad hoc reporting against databases using COTS tools	The highest defined Level has been attained.

Business Enabling Services			
Technical Area	Level	MITA 2.0 Description	Gap Analysis
DS: Data Mining	1	Data mining to detect patterns in large volumes of data, typically using coded procedures	The use of JasperReports may meet the Level 2 requirements. However, the documentation provided mentioning JasperReports is lacking in specifics. This area may indeed be a higher level, but there was no explicit data mining COTS tool mentioned.
DS: Statistical Analysis	2	Statistical analyses of designated data (e.g., regression analysis) using COTS tools	The highest defined Maturity Level has been attained.
DS: Neural Network Tools	1	Level 1 has not been defined.	The documentation provided does not state whether or not the system contains neural network tools.

### Access Channels

The Access Channels technical area is concerned with the area of the system which handles the user's ability to access the system. Accessibility, according to the MITA Framework 2.0, is defined as person to system access. The greater the accessibility to the system, the more aligned that system will be with the MITA Framework 2.0. This technical area can be broken down into two sub-technical areas: Portal Access, and Support for Access Devices. The assessment of the two sub-technical areas is addressed below.

Access Channels			
Technical Area	Level	MITA 2.0 Description	Gap Analysis
Portal Access	3	Beneficiary and provider access to appropriate Medicaid business functions via portal with single online access point	The highest defined Maturity Level has been attained.
Support for Access Devices	2	Beneficiary and provider access to services via browser, kiosk, voice response system, or mobile phone	There is no documentation provided supporting the conclusion that the NewMMIS will provide access via PDAs.

### Interoperability

The Interoperability technical area promotes organized and efficient system to system communication. The more interoperable a system becomes the more agile and responsive it becomes to system changes. This technical area is also important in ensuring the system becomes technology neutral. Overall, the goal of obtaining interoperability is to have a system where diverse systems can work together. This area can be broken down into 3 sub-technical areas: Service Oriented Architecture, Standards-Based Data Exchange, and Integration of Legacy Systems. The Service Oriented Architecture can be broken down further into 3 sub-technical areas: Service Structuring and Invocation, Enterprise Service Bus, and Orchestration and Composition. The assessment of these areas can be seen below.

Interoperability			
Technical Area	Level	MITA 2.0 Description	Gap Analysis
Service Oriented Architecture	3	High Level Technical Area encompassing the three SOA Sub-Technical Areas below	High Level Technical Area, read below for more information about Gaps in this area.

Interoperability			
Technical Area	Level	MITA 2.0 Description	Gap Analysis
SOA: Service Structuring and Invocation	3	Services support using architecture that complies with published MITA interfaces and interface standards	The documentation provided is not definitive enough regarding the use of a true cross-enterprise services registry.
SOA: Enterprise Service Bus	3	MITA-compliant ESB	There is no documentation provided to support the Level 4 requirement that there be a MITA-compliant ESB interoperable outside of a State Medicaid agency
SOA: Orchestration and Composition	3	MITA-standard approach to orchestrating and composing services	The highest defined Maturity Level has been attained.
Standards-Based Data Exchange	3	Data exchange (internally and externally) using MITA standards	There is no documentation provided to support the conclusion that the NewMMIS will utilize internal and external data exchange in conformance with MITA-defined semantic ontology based data standards.
Integration of Legacy Systems	3	Service-enabling legacy systems using MITA-standard service interfaces	The highest defined Maturity Level has been attained.

### Data Management and Sharing

According to the MITA Framework 2.0, the Data Management and Sharing technical area provides a structure that facilitates the development of information/data that can be effectively shared across a State's Medicaid enterprise boundaries to improve mission

performance. It also provides an impetus for State Medicaid agencies to better understand their data and how it fits in the total realm of Medicaid information. The DMS addresses fundamental areas necessary to enable information sharing opportunities and to position State Medicaid agencies to operate in an environment of global information. This technical area can be broken down into 2 sub-technical areas: Data Exchange Across Multiple Organizations and Adoption of Data Standards. The assessment of these areas can be seen below.

<b>Data Management and Sharing</b>			
<b>Technical Area</b>	<b>Level</b>	<b>MITA 2.0 Description</b>	<b>Gap Analysis</b>
Data Exchange Across Multiple Organizations	2	Electronic data exchange with multiple organizations via a MITA information hub using secure data, in which the location and format are transparent to the user and the results are delivered in a defined style that meets the user's needs	There is no documentation provided to support the conclusion that the NewMMIS has a MITA information hub that can perform advanced information monitoring and route alerts/alarms to communities of interest if the system detects unusual conditions
Adoption of Data Standards	1	No use of enterprise wide data standards	The MITA Information Model has yet to be fully developed. Therefore, the Level 1 score is attained. There no gap on the side of the EOHHS. It would be worth noting, though, that providing a data model in the system's documentation would be helpful for future reference. The documentation provided does not contain a data model.

### **Performance Measurement**

The Performance Measurement technical area tracks performance and alerts stakeholders for any activity which falls outside of the acceptable criteria. A common transformation approach has yet to be defined in the MITA Framework 2.0. As of today, this technical area will perform system and program monitoring which keeps management informed on the status of the overall Medicaid System. This technical area can be broken down into 2 sub-technical areas: Performance Data Collection and Reporting, and Dashboard Generation. The assessment of these areas can be seen below.

Performance Measurement			
Technical Area	Level	MITA 2.0 Description	Gap Analysis
Performance Data Collection and Reporting	2*	Collect and report using predefined and ad hoc reporting methods and currently defined performance metrics	The highest defined Maturity Level that can be attained in this area is Level 4. The documentation provided does not support a Level 4 because it does not say if the system can generate alerts for programmatic performance that falls outside of predetermined metrics.
Dashboard Generation	2	Generate and display summary-level performance information (i.e., performance dashboards)	There is no documentation to support the system providing dashboards from internal or external sources for MITA –defined metrics.
*This assessment score is based on <u>program performance</u> measurement not <u>system performance</u> measurement			

## Security and Privacy

The Security and Privacy technical area promotes standards that will provide a level of consistency focused on the tactical sharing of data. Security and Privacy standards will address policies, management procedures, and technical services that cover technical functions (e.g., authentication, authorization, and auditing) and ensure that security policies are enforced between MITA services. This area can be broken down into 6 sub-technical areas: Authentication, Authentication Devices, Authorization and Access Control, Intrusion

Detection, Logging and Auditing, and Privacy. The assessment of these areas can be seen below.

Security and Privacy			
Technical Area	Level	MITA 2.0 Description	Gap Analysis
Authentication	3	User authentication using public key infrastructure in conformance with MITA-identified standards	The highest defined Maturity Level has been attained.
Authentication Devices	1	Undefined	There is no documentation provided supporting the conclusion that the NewMMIS will use biometric technology (fingerprints, retinal scans) or SecureID tokens for authentication.
Authorization and Access Control	2	User access to system resources depending on their role at sign-on	The highest defined Maturity Level has been attained.
Intrusion Detection	1	Undefined	This Technical Area and all of its Maturity Levels are currently undefined by CMS. Therefore, there is no gap in documentation.
Logging and Auditing	2	Access to the history of a user's activities and other management functions, including logon approvals and disapprovals and log search and playback	The highest defined Maturity Level has been attained.
Privacy	3	Access restriction to data elements based on defined access roles	The highest defined Maturity Level has been attained.

### Flexibility – Adaptability and Extensibility

The Flexibility – Adaptability and Extensibility technical area promotes an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology in Massachusetts, fulfilling one of the major goals of the MITA Framework 2.0. Adaptability and extensibility also promote modularity, component reuse, interoperability,

and integration using open architecture. The table below documents the Maturity Levels at which the processes in this technical area are performed within the Massachusetts Medicaid Enterprise. This area can be broken down into 4 areas: Rules – Driven Processing, Extensibility, Automate Configuration and Reconfiguration Services, and Introduction of New Technology. The assessment of these areas can be seen below.

<b>Flexibility – Adaptability and Extensibility</b>			
<b>Technical Area</b>	<b>Level</b>	<b>MITA 2.0 Description</b>	<b>Gap Analysis</b>
Rules – Driven Processing	1	Manual application of rules (and consequent inconsistent decision making)	The NewMMIS documentation provided does not support the conclusion that there is a true BRMS such as Blaze Advisor, JRules, Haley, Visual Rules, or InRule. There is also no documentation provided supporting advanced BRMS.
Extensibility	3	Services with points at which to add extensions to existing functionality (changes highly localized)	The highest defined Maturity Level has been attained.
Automate Configuration and Reconfiguration Services	1	Configuration and reconfiguration of distributed application that typically requires extensive hard-coded changes across many software components and/or applications across the enterprise (and with significant disruption)	Levels 4 and 5 have duplicate definitions in this area. The requirement for a Level 4 assessment is that a system has consistent distributed applications using common business change processes that coordinate between active components and ensure minimal disruption. The documentation provided does not support this conclusion.

### Flexibility – Adaptability and Extensibility

Technical Area	Level	MITA 2.0 Description	Gap Analysis
Introduction of New Technology	3	Technology-neutral interfaces that localize and minimize the impact of the introduction of new technology (e.g., data abstraction in data management services to provide product neutral access to data based on metadata definitions)	The highest defined Maturity Level has been attained.

## Recommendations

### Overall Recommendations

Based on the gaps identified above, 4TG offers the following recommendations to EOHHS for obtaining the missing and/or insufficient information:

- ◆ Ensure that all procedures and processes are fully documented by creating materials, such as approved handbooks or policy and procedures manuals, for each of the business process characteristics identified in this Gap Analysis
- ◆ Update existing documentation with the newly created or identified information, as appropriate
- ◆ Include the ability for the MITA assessment vendor or EOHHS staff persons assigned to conduct the assessment, to interact with and interview Commonwealth subject matter experts (SMEs) to discuss each MITA business and technical area, ascertain the existence of a process and determine whether or not the process is documented
- ◆ Institute a process to educate EOHHS staff about the MITA standards, business processes, capabilities, characteristics and measures to ensure that the ongoing business and technical processes and documentation incorporate the needed MITA information
- ◆ Identify and establish communication with the Commonwealth SMEs who are most knowledgeable about the business and technical processes encompassed by MITA, for example, the SME who is most familiar with the Settlement process
- ◆ Continue to work with the NewMMIS vendors and internal staff to further develop the business and technical process documentation, describing how the processes will be conducted using the NewMMIS. This effort will improve the results of future MITA assessment activity and also support the MMIS certification efforts
- ◆ Use internal or external audits related to staff effectiveness and efficiency, or provider or member satisfaction surveys, to potentially answer questions/measures related to the efficiency, effectiveness, accuracy, timeliness and quality of the EOHHS processes
- ◆ Determine and implement the most appropriate option for tracking the missing or insufficient documentation. The following are some recommended options for completing this critical task:
  - Assign the appropriate Commonwealth SMEs the task of locating and/or preparing the missing or insufficient documentation for his or her process. Such process documentation should be prepared, internally reviewed and approved to ensure that it covers the process and incorporates the MITA standards, areas, capabilities, characteristics and measures. When

approved, the documentation should be added to the EOHHS MITA Library stored in the MATT tool.

- Consider contracting with a vendor who is familiar with MITA to assist EOHHS in developing missing and insufficient documentation. This recommendation would require that the vendor have access to the appropriate Commonwealth SMEs for the identified business processes. Again, the documentation would need to be internally reviewed and approved by EOHHS and added to the EOHHS MITA Library..
- A combination of the both of the above options.

**BCM Specific Recommendations**

The MITA BCM Gap Analysis identifies the where the Maturity Level determinations are incomplete or weak due to lack of documentation. This analysis also identifies the specific measures that could not be affirmed for each business process for which 4TG had adequate documentation to perform an assessment.

The overall average Maturity Level for all MITA defined business areas is at a **Level 1** meaning that EOHHS “focuses on meeting compliance thresholds for state and Federal regulations, aiming primarily at accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.”

FourThought Group recommends that EOHHS create documentation for or augment existing documentation with the identified measures listed in the table below. These characteristics and measures represent those 4TG was unable to affirm using the documentation provided. Documentation for these measures will enable EOHHS to fully affirm the business processes at the current Maturity Level and potentially to affirm some business processes at a higher Maturity Level. Each of the specific missing measures is identified for the business process in the Gap Analysis tables above. This recommendation is in addition to need for EOHHS to develop documentation for the business processes for which there was no documentation provided.

Business Area	Characteristics and Measures
Member Management	Cost effectiveness, staffing, efficiency, accuracy, quality, timeliness, storage and data formats for enrollment and disenrollment, notification of contractors, timeliness of responses to providers, updates to member information, availability of member information, availability of data for users, system limitations, validation and reconciliation of member data, validation of responses, the quality of the information that members receive, member outreach, and the impact of outreach.
Provider Management	Increased value to stakeholders,, staffing, member satisfaction, provider performance, accuracy, outreach and education, and whether increased automation resulted in the need for fewer staff
Contractor Management	Contract validation and verification, efficiency, quality, the closeout of a contract process, staffing, comparability accuracy, quality, notification of changes made to users and processes, timeliness, outreach targeting, accuracy of responses, decision consistency, and provider case assistance and communication issues

Business Area	Characteristics and Measures
Operations Management	Increased accuracy, staffing, programmatic and cost efficiency, quality, error rate reduction, use of MITA standard interfaces, the level of automation for single claims adjustments, coordination with other agencies in the EOB process, increased value to stakeholders, timeliness, whether increased automation allows the agency to focus on cost management, transaction standards, manual processes, enrollment of members in health insurance, premium payments, use of national standards, use of paper invoices for drug rebates, manual validation of rebates,, use of standard data, labor intensity of the process,
Program Management	Develop documentation for this entire business area as no documentation was provided for this business area
Care Management	Accuracy of contact information, the production and use of health education and outreach materials, population targeting processes, timeliness, access to enrolment records, staffing, efficiency, accuracy and quality
Program Integrity	Develop documentation for this entire business area as no documentation was provided for this business area
Business Relationship Management	Application validation,, timeliness, staffing, efficiency, accuracy, quality, the impact of communications on stakeholders, and the targeting Business Partners

### TCM Specific Recommendations

The MITA TCM Gap Analysis presents the deficiencies in documentation provided by the Commonwealth as they relate to each of the technical areas within the MITA Framework 2.0. Each technical area is assessed at each Maturity Level. Those capabilities which are not addressed in the documentation are considered to be gaps that will need to be addressed by EOHHS. This assessment was also performed strictly with documentation provided by EOHHS. As a result, there may be processes and procedures that are currently being used but are not documented in the materials provided to 4TG.

The overall average capability Maturity Level of EOHHS for all MITA technical areas is at a **Level 2**, meaning that the EOHHS “is moderately aligned with optimal MITA system specifications using a combination of manual and electronic processes and some basic Service Oriented Architecture Principles.” While various aspects of the Medicaid Enterprise operate at higher Maturity Levels using nationally recognized enterprise standards, the incomplete nature of the Technical Capabilities Matrix as defined in the MITA Framework 2.0 makes it difficult to achieve a higher Maturity Level.

The following are specific recommendations based on the gap analysis performed on the NewMMIS. Take note that the higher level technical areas of Decision Support and interoperability are included in the recommendations below by virtue of all their sub-technical areas being addressed.

- ◆ Business Enabling Services

- The documentation provided does not specifically address the Business Relationship Management area. It may be helpful to locate any documentation on the NewMMIS which relates to tracking the relationships between Medicaid system users and the services they have requested and

received. If this is done, the assessment score for this area could increase from a Level 1 to a Level 3.

- The documentation provided calls for the need of advanced foreign language support. If this capability is added, it would benefit EOHHS to document this additional functionality. This will make it easier to upgrade the assessment score for this Foreign Language Support area if the SS-A needs to be updated in the future. This system upgrade would increase the assessment score for this area from a Level 1 to a Level 3.
  - The use of data marts within the system is currently possible given the implementation of the NewMMIS. If Data Marts are currently being used or are planned to be implemented, the documentation should reflect this for future updates to the SS-A. This will especially be important once the MITA Logical Data Model (LDM) is fully released to the public. Aligning data marts with the MITA LDM will increase the score in the Data Marts area from a Level 1 to a Level 3.
  - The Data Mining area can also be upgraded in score from a Level 1 to a Level 2 assessment if there is a commercial over the shelf (COTS) product being used to detect patterns in large volumes of data. If a COTS product is being implemented for this purpose in the future, it should be documented so that it can be reflected in future revisions of the SS-A.
  - The system shows no documentation provided for Neural Network Tools. If added in the future, this needs to be documented and will increase the score in the area from a Level 1 to a Level 2.
- ◆ Access Channels
- The NewMMIS has no documentation provided stating it can be accessible via Personal Digital Assistant (PDA) devices. If the system has or will have the capability in the future, the documentation needs to be updated to reflect this. Doing so could increase EOHHS' score in the Support for Access Devices area from a Level 2 to a Level 3.
- ◆ Interoperability
- There is no documentation provided stating the NewMMIS has a cross-enterprise service registry. If the system does have this capability it needs to be more thoroughly documented. If this is the case or the capability is added in the future, then Service Structuring and Invocation area's score can be increased from a Level 3 to a Level 4.
  - The documentation provided regarding the Enterprise Service Bus (ESB) technical area does not explicitly state whether or not the NewMMIS' ESB will be interoperable outside of the EOHHS. If this is the case, or become so in the future, this area's score could be upgraded from a Level 3 to a Level 4.
  - Currently the score for the Standards-Based Data Exchange area is a Level 3. Once CMS fully discloses the MITA-defined semantic data standards the standards for data exchange within the NewMMIS could

possibly be updated to meet the newer criteria. If this becomes the case, the score for this area could be increased from a Level 3 to a Level 5.

◆ Data Management and Sharing

- The Data Exchange Across Multiple Organizations area will be able to attain a higher score once the MITA Information Model is fully developed. Once this occurs, the upgraded score will depend on the extent of control and monitoring EOHHS will have on the electronic data exchange.
- The MITA Information Model has yet to be fully developed. This is not gap on the part of the EOHHS. However, once the data model is developed, the system should be upgraded to follow this model for consistency. Once this occurs, the Adoption of Data Standards areas score can be upgraded to the appropriate Maturity Level. The extent to which data is shared determines the score of this area.

◆ Performance Measurement

- The documentation provided for the Performance Data Collection and Reporting area does not address the programmatic performance of the NewMMIS. If a defined process is developed that tracks MITA defined performance metrics in the future, the score for this area can be upgraded from a Level 2 to a Level 3. If the performance reporting capability of the NewMMIS generates alerts based on the usage of bench marks, the areas score can be upgraded to a Level 4.
- The documentation provided for the area of Dashboard Generation only goes as far as mentioning JasperReports which has the ability to allow for this capability. The system may in fact have a higher Maturity Level in this area but is it not clear if this is the case. Once the MITA defined metrics have been developed, the dashboards can be adjusted to display information based on these metrics. If this becomes the case, the area's score can be adjusted from a Level 2 to a Level 3. To achieve a Level 4, the enhancement allowing external data sources to be used outside of EOHHS must be implemented.

◆ Security and Privacy

- From the information provided, the NewMMIS does not have any documented authentication devices making use of biometrics or SecureID tokens. If this capability is added, this needs to be reflected in future documentation. Doing so would increase the score in the Authentication Devices area from a Level 1 to upwards of a Level 5 depending on the authentication device used: fingerprint authentication results in a Level 3 score, SecureID tokens result in a Level 4 score, and retinal scan authentication results in a Level 5 score.

◆ Flexibility – Adaptability and Extensibility

- The documentation provided does not address whether there will be a true Rules Management System (RMS). Documentation was provided which stated the NewMMIS has a table-driven design ensures that EOHHS can make modifications to system functions by changing data in tables rather

than recoding programs. This table structure provides for linking a defined set of rules into business processes. The documentation, however, is not clear as to whether this is as robust as a rules engine. If so, the documentation should be updated to reflect this and the assessment score for the Rules-Driven Processing area could be increased from a Level 1 to a Level 3. If not, the addition of a true rules engine would also increase the score of this area to a Level 3.

- There is no justification in the documentation provided to confirm that the NewMMIS has consistent distributed applications using common business change processes that coordinate between active components and ensure minimal disruption. If this does occur, the Automate Configuration and Reconfiguration Services area's score could be upgraded from a Level 1 to a Level 4 or 5 depending on whether CMS addresses the issue of duplicate Maturity Level definitions in the future.



## Appendix A – As-Is Assessment Scoring Notes Report

The As-Is Assessment Scoring Notes Report previously submitted with the BCM is attached for reference. For each Business Area, this detailed report includes all Business Processes, Business Capabilities, characteristics/qualities, measures/questions and notes across all the capability Maturity Levels, as well as the Maturity Level scoring for each area.

This report is included as an external document within the Massachusetts Project Portal on SharePoint. It is named: Appendix A Assessment Scoring Notes Report.pdf and can be accessed at:

## Appendix B – Lack of Technical Definitions and Documentation Table

TCM Capability Breakdown					
Technical Areas	L1	L2	L3	L4	L5
B.1 Forms Management	A	A	U	U	U
B.2 Workflow Management	A	A	U	U	U
B.3 Business Process Management (BPM)	A	U	A	U	U
B.4 Business Relationship Management (BRM)	A	U	ND	ND	U
B.5 Foreign Language Support	ND	U	ND	U	U
B.6.1 Data Warehouse	U	U	ND*	U	U
B.6.2 Data Marts	U	U	ND	U	U
B.6.3 Ad hoc Reporting	A	A	U	U	U
B.6.4 Data Mining	A	ND	U	U	U
B.6.5 Statistical Analysis	A	A	U	U	U
B.6.6 Neural Network Tools	ND	ND	U	U	U
A.1 Portal Access	A	A	A	U	U
A.2 Support for Access Devices	A	A	ND	U	U
I.1.1 Service Structuring and Invocation	A	A	A	ND	U
I.1.2 Enterprise Service Bus	A	A	A	ND	U
I.1.3 Orchestration and Composition	A	U	A	U	U
I.2 Standards-Based Data Exchange	A	U	A	U	ND
I.3 Integration of Legacy Systems	A	U	A	U	U
D.1 Data Exchange Across Multiple Organizations	A	A	ND	U	U
D.2 Adoption of Data Standards	A	ND*	ND*	ND*	ND*
P.1 Performance Data Collection and Reporting	U	A	ND	ND	U
P.2 Dashboard Generation	U	A	A	U	ND
S.1 Authentication MM	A	U	A	U	U
S.2 Authentication Devices	U	U	ND	ND	ND
S.3 Authorization and Access Control	U	A	U	U	U
S.4 Intrusion Detection	U	U	U	U	U
S.5 Logging and Auditing	A	A	U	U	U
S.6 Privacy	A	U	A	U	U
F.1 Rules-Driven Processing	A	U	ND	U	U
F.2 Extensibility	A	U	A	U	U
F.3 Automate Configuration and Reconfiguration Services	A	U	U	ND	ND
F.4 Introduction of New Technology	A	U	A	U	U
<b>Legend</b>					
U	Undefined By CMS				
ND	Not Documented				
A	Affirmed				
ND*	Information Architecture Not Fully Developed				