

8.0 GLOSSARY

The following abbreviations are used throughout this document:

APC	Ambulatory Patient Classification
APD	Advanced Planning Document
ASC	Accredited Standards Committee
BCCTP	Breast and Cervical Cancer Program
BCM	Business Capability Matrix
BHDDH	Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
BPM	Business Process Model
CDM	Consumer Direction Module
CEDARR	Comprehensive Evaluation Diagnosis Assessment Referral and Reevaluation
CMS	Centers for Medicare and Medicaid
CNOM	Cost Not Otherwise Matched
COB	Coordination of Benefits
CSHCN	Children with Special Health Care Needs
CSM	Community Support Management
DCYF	Department of Children, Youth and Families
DEA	Department of Elderly Affairs
DHS	Department of Human Services
DMV	Department of Motor Vehicles
DRG	Diagnosis Related Grouping
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EHR	Electronic Health Record

EOB	Explanation of Benefits
EOHHS	Executive Office of Health and Human Services
FA	Fiscal Agent
FACN	Fiscal Agent Change Notice
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentages
FPL	Federal Poverty Level
HBTS	Home Based Therapeutic Services
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HIX	Health Insurance eXchange
HP	Hewlett Packard
HSC	Hubbert Systems Consulting
IA	Interagency Agreement
LTC	Long-Term Care
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MR/DD	Mental Retardation/Developmentally Disabled
NDC	National Drug Code

OCM	Organizational Change Management
OCP	Office of Community Programs
OICSS	Office of Institutions and Community Services and Support
OMR	Office of Medical Review
ORS	Office of Rehabilitation
PA	Prior Authorization
PASSR	Pre-Admission Screening and Resident Review
PASSR	Personal Assistance Services and Support
PCCM	Primary Care Case Management
PCG	Public Consulting Group
PCP	Primary Care Physician
REOMB	Recipient Explanation of Member Benefits
RFP	Request for Proposal
RI	Rhode Island
RIPTA	Rhode Island Public Transportation Authority
SS-A	State Self-Assessment
TPL	Third Party Liability

9.0 APPENDIX A: CURRENT VIEW OF DHS BUSINESS PROCESSES AND CAPABILITIES

See attached.

10.0 APPENDIX B: DHS'S TARGET CAPABILITIES

See attached.

11.0 APPENDIX C: MITA I-APD ATTACHMENT

MITA BPM Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"
Business Relationship Management	Establish RI Medicaid Business Relationship	1	1	2
Business Relationship Management	Manage RI Medicaid Business Relationship Communications	N/A	1	2
Business Relationship Management	Terminate RI Medicaid Business Relationship	N/A	1	2
Business Relationship Management	Manage RI Medicaid Business Relationship	1	1	2
Care Management	Manage Registry	N/A	2	3
Care Management	Manage Case	1	2	3
Care Management	Manage RI Medicaid Population Health	1	2	3
Contractor Management	Inquire Contractor Information	1	2	3
Contractor Management	Perform Potential Contractor Outreach	1	2	3
Contractor Management	Manage Administrative/Health Services Contract	1	2	2
Contractor Management	Award Administrative/Health Services Contract	1	2	2
Contractor Management	Manage Contractor Communication	N/A	2	3
Contractor Management	Close out Administrative/Health Services Contract	1	2	2
Contractor Management	Manage Contractor Information	1	1	3
Contractor Management	Support Contractor Grievance and Appeal	1	2	3
Member Management	Inquire RI Medicaid Member Eligibility	2	3	4
Member Management	Manage RI Medicaid Applicant and Member Communication	1	3	3
Member Management	Determine BCCTP Eligibility	1	N/A	N/A
Member Management	Disenroll RI Medicaid Member	1	3	4
Member Management	Determine RI Medicaid Eligibility	1	3	4

MITA BPM Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"
Member Management	Determine Respite Eligibility	1	N/A	N/A
Member Management	Perform RI Medicaid Population and Member Outreach	1	3	4
Member Management	Manage RI Medicaid Member Information	1	3	4
Member Management	Manage RI Medicaid Member Grievance and Appeal	1	2	3
Member Management	Manage BCCTP Member Information	1	N/A	N/A
Member Management	Enroll Managed Care Member	1	3	4
Operations Management	Authorize RI Medicaid Service	1	2	3
Operations Management	Inquire RI Medicaid Payment Status	2	3	4
Operations Management	Prepare RI Medicaid Remittance Advice	3	3	4
Operations Management	Prepare Medicare Premium Payment	1	N/A	N/A
Operations Management	Prepare RIte Share Premium Payment	3	3	3
Operations Management	Prepare Capitation Premium Payment	3	N/A	N/A
Operations Management	Prepare RI Medicaid Provider and Priemium EFT	2	3	4
Operations Management	Price RI Medicaid Claim	2	2	3
Operations Management	Edit and Audit RI Medicaid Encounter	1	2	3
Operations Management	Edit and Audit RI Medicaid Claim	2	2	3
Operations Management	Apply Void and Replace	2	2	3
Operations Management	Authorize Personal Choice Waiver Service	1	N/A	N/A
Operations Management	Calculate Medically Needy Spend-Down Amount	1	1	2
Operations Management	Manage Hosptial Cost Settlement	1	2	3
Operations Management	Establish Care Plan	1	2	3
Operations Management	Manage RI Medicaid Drug Rebate	2	2	3

MITA BPM Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"
Operations Management	Manage RI Medicaid Recoupment	2	3	4
Operations Management	Manage RI Medicaid TPL Recovery	1	2	3
Operations Management	Apply RI Medicaid Claim Attachment	1	2	3
Operations Management	Prepare REOMB	1	3	4
Operations Management	Manage RI Medicaid Estate Recovery	1	2	3
Operations Management	Prepare RIte Care Member Premium Invoice	3	3	3
Program Integrity Management	Identify RI Medicaid Candidate Case	2	3	4
Program Integrity Management	Manage RI Medicaid Case	1	3	4
Program Management	Generate Financial and Program Analysis Report	2	2	3
Program Management	Perform Accounting Functions	2	2	3
Program Management	Develop and Manage Performance Measures and Reporting	2	3	3
Program Management	Manage Managed Care Rate Setting	1	2	3
Program Management	Maintain Benefits-Reference Information	2	2	3
Program Management	Manage 1099s	2	2	3
Program Management	Maintain State Plan	1	1	2
Program Management	Manage FMAP	1	2	3
Program Management	Manage FFP for MMIS	1	2	3
Program Management	Formulate Budget	1	2	2
Program Management	Designate Approved Drug Formulary	2	2	3
Program Management	Designate Approved Medicaid Service	2	2	3
Program Management	Develop and Maintain Benefit Package	1	1	2
Program Management	Manage Standard RI Medicaid Rate Setting	1	2	3

MITA BPM Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"
Program Management	Manage State Funds	1	2	3
Program Management	Develop Agency Goals and Objectives	1	2	3
Program Management	Manage RI Medicaid Program Information	2	2	3
Program Management	Develop and Maintain Program Policy	1	2	3
Provider Management	Disenroll RI Medicaid Provider	1	2	3
Provider Management	Enroll RI Medicaid Provider	1	2	3
Provider Management	Inquire RI Medicaid Provider Information	2	2	3
Provider Management	Manage RI Medicaid Provider Grievance and Appeal	1	1	2
Provider Management	Manage RI Medicaid Provider Information	1	2	3
Provider Management	Manage RI Provider Communication	2	2	3
State Specific	Perform Provider Enrollment Certification	1	2	3

12.0 APPENDIX D: MITA BUSINESS PROCESS MODEL

13.0 APPENDIX E: MITA BUSINESS CAPABILITY MATRIX

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1 READER'S GUIDE

The Current View Appendix is organized into sections according to the MITA Business Areas. Within each Business Area, business processes are mapped to the MITA BPM, variations from the MITA definition are noted and a discussion of the current business process maturity is included. Each section following the MITA Business Area is described below.

Section Name	Section Description
RI Business Process Name	Indicates the name given to the RI business process.
MITA Business Process	Contains the MITA Business Process and the description from the MITA Framework.
Overview	An overview of the RI business process.
Business Process Variation	This section contains information on how the RI business process varies from the MITA Framework definition. It notes additional steps performed by RI, whether a step is performed differently as well as if a step is not applicable to the RI process. If the MITA Framework does not have a complete business process definition, it indicates that one was created for RI. The RI specific business process definition can also be found in the Appendix which contains the BPM.
Systems and Datasets	A listing all of systems and datasets used to perform the RI business process.
Maturity Characteristics	Includes the Figure "Current Maturity Levels by Dimension" which contains the maturity level ratings assessed for the RI business process based upon the MITA Framework BCM. Also includes specific examples that support the ratings. The last area is the Table "Assessed Maturity Level by MiTA Quality" which includes the detailed language from the MITA Framework BCM that corresponds to the ratings assessed. This gives the reader the specific MITA language behind the rating level. The ratings are based upon interviews with state staff and vendors as necessary.

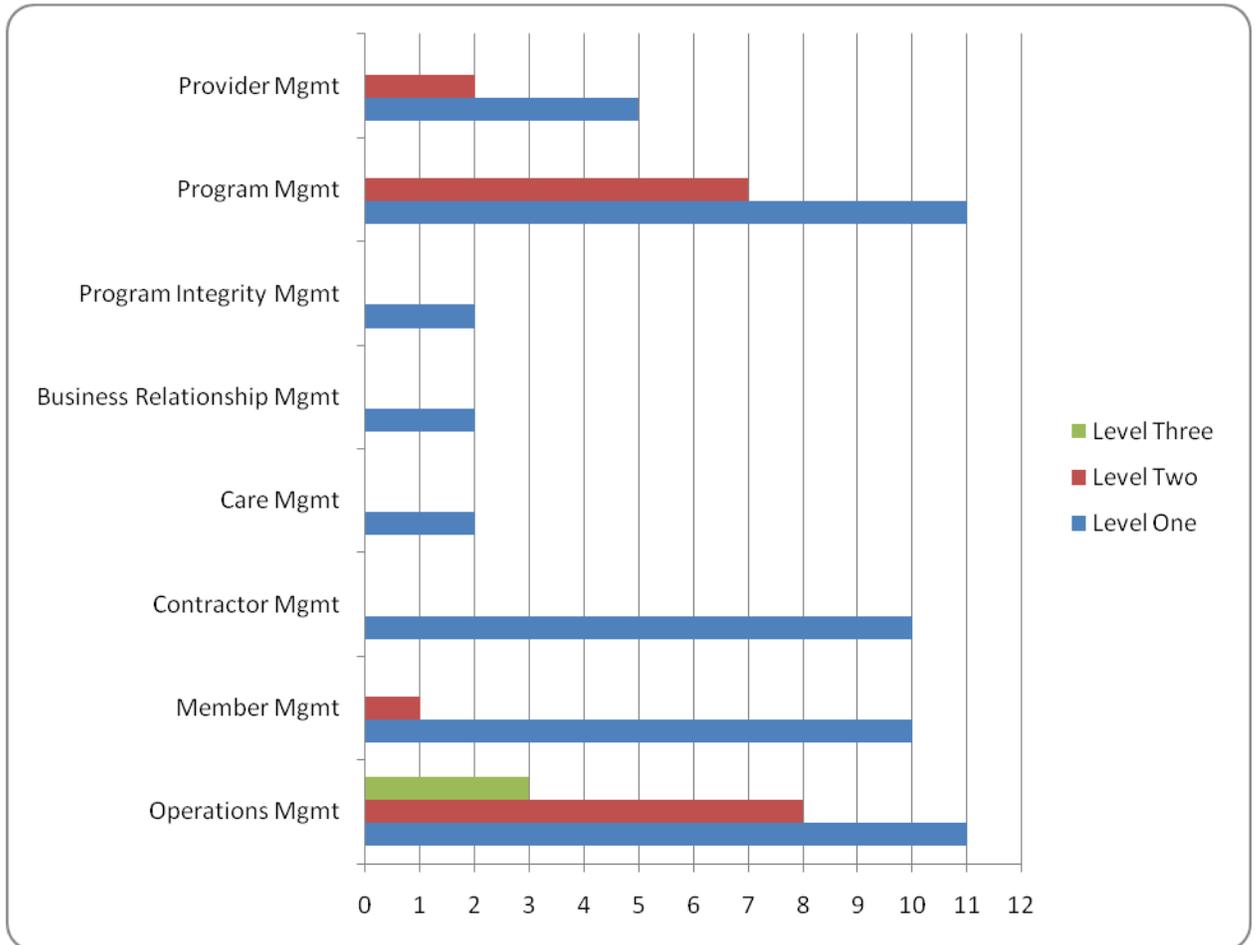
2 SUMMARY FINDINGS

The Operations Management area showed the highest level of maturity with several business processes rated at a Level 3. Several business processes have eliminated the use of non-electronic data interchange to the extent feasible and comply with HIPAA and national standards. These higher ratings are seen mostly within the premium payment related business processes.

The least mature areas across the RI Medicaid program are within Business Relationship Management, Care Management, Program Integrity Management, and Contractor Management. With most business processes capabilities currently at a Level 1, the degree of automation, standardization and data integration is limited. It should be noted that there are business processes that currently rate at Level 2 including specific processes within areas such as Provider Management, Operations Management, Member Management and Program Management. These current processes should be reviewed during transition planning as a means of leveraging their maturity to improve the maturity of other RI Medicaid business processes. Each individual RI Medicaid business process and their maturity ratings are discussed in the sections that follow.

The total number of business processes by capability level across each MITA business areas is depicted in the figure below.

Figure 1 Current Maturity Levels by Business Area

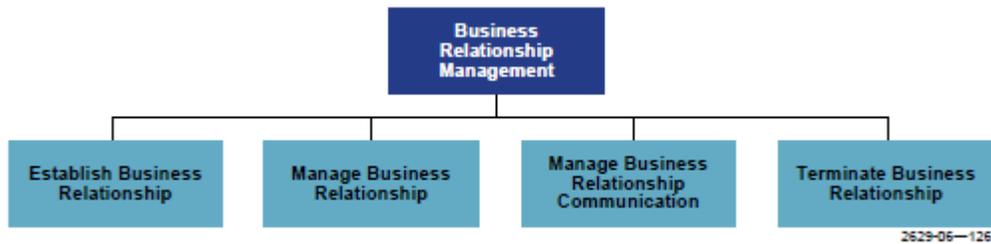


A summary of the mapping of the State’s business processes to the MITA definitions are included in Appendix A. Also included is a table of the 11 MITA business processes that were not mapped to a RI business process.

Appendix B and C contain the MITA Business Process Model and the enhance MITA Business Capability Matrix used for the current view assessment.

3 BUSINESS RELATIONSHIP MANAGEMENT

There are four business processes defined within the MITA framework for Business Relationship Management.



The RI Medicaid program performs two of the defined business processes:

- Establish Business Relationship
- Manage Business Relationship

The following MITA Business Processes are not performed by RI:

- Manage Business Relationship Communication – No formal process exists.
- Terminate Business Relationship – No formal process exists. Interagency Service Agreements expire.

3.1 Establish RI Medicaid Business Relationship

3.1.1 MITA Business Process

Tier 2: Establish Business Relationship	
Item	Details
Description	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 (MOUs) with other agencies, electronic data interchange agreements with providers, managed care organizations, and others, and CMS, other Federal agencies, and Regional Health Information Organizations (RHIOs).

3.1.2 RI Business Process Overview

The Establish RI Medicaid Business Relationship process is overseen by the Department of Human Services (DHS). This process is decentralized and involves various agencies, programs, providers and other parties. DHS is responsible for entering in an agreement with entities requesting to do business with the Department.

This agreement is generally referred to as an Inter-agency Service Agreement (ISA) or Memorandum of Understanding (MOU). Although this is not a formal process and is not centralized, DHS currently does business with entities such as:

- The Department of Elderly Affairs (DEA)
- The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)
- The Department of Children, Youth and Families (DCYF)
- Rhode Island Department of Education (RIDE)
- Rhode Island Department of Human Services/Office of Rehabilitation Services (DHS/ORS)

- State Institutions of Higher Education (University of Rhode Island, Rhode Island College and The Community College of Rhode Island)
- Rhode Island Public Transportation Authority (RIPTA)

3.1.3 Business Process Variations

The Establish RI Medicaid Business Relationship business process does not significantly diverge from the MITA business process definition.

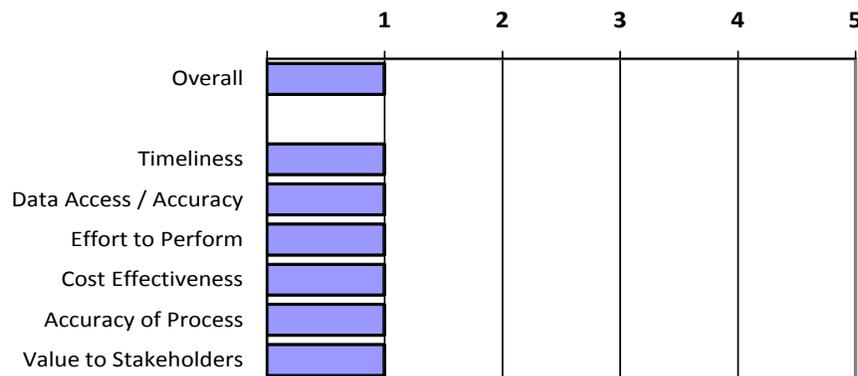
3.1.4 Systems and Datasets

Establish RI Medicaid Business relationship is a manual process and is not supported by any major systems.

3.1.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Establish RI Medicaid Business Relationship process is rated at a Level 1 capability. The process is performed with no automation and information is not exchanged efficiently throughout the process. There are few standards enforced in this process.

Figure 2: Current Maturity Levels by Dimension: Establish RI Medicaid Business Relationship



Examples of the qualities and characteristics that support these ratings include the following:

- Program areas contact Budgets & Accounting via phone and email to facilitate the process for execution of an Interagency Agreement (IA).
- Standards do not exist for initiating formal business relationships (e.g., establishing MOUs or ISAs)
- The process has no automation and is labor intensive

Table 1: Assessed Maturity Level by MITA Quality: Establish RI Medicaid Business Relationship

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.	1
Data Access & Accuracy	1
Mix of manual and automated processes. (This business process is completely manual at this time.)	1
Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI. (There is no EDI of any type at this time.)	1
There is no single standard for data stored for different types of data (eg, types of providers). (IAs are currently stored as MS Word or .PDF documents on a shared server.)	N/A
Staff researches, maintains, and responds to information requests manually.	1
Customers have difficulty accessing consistent, quality, or complete information (e.g., about programs or services).	N/A
Program areas require different rules / criteria and access points for similar business functions.	N/A
Effort to Perform	1
Updates are completed (keyed) manually.	1
Cost Effectiveness	1
Large number of staff required to perform business process. (Relative to RI.)	1
Accuracy of Process	1

MITA BCM Qualities & Characteristics	Level
Inconsistent decision making/validation..	1
Utility or Value to Stakeholders	1
Focus is on conducting business functions as efficiently as possible.	1

3.2 Manage RI Medicaid Business Relationship

3.2.1 MITA Business Process

Tier 2: Manage Business Relationship	
Item	Details
Description	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.

3.2.2 RI Business Process Overview

The Manage RI Medicaid Business Relationship process is overseen by the Department of Human Services (DHS). This process is decentralized and involves various agencies, programs, providers and other parties. DHS is responsible for maintaining 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.

3.2.3 Business Process Variations

The Manage RI Medicaid Business Relationship business process does not significantly diverge from the MITA business process definition.

3.2.4 Systems and Datasets

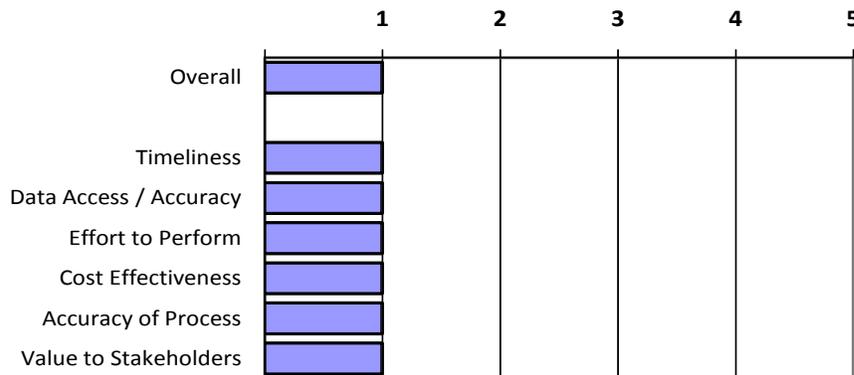
Manage RI Medicaid Business relationship is a manual process and is not supported by any major systems.

3.2.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Business Relationship process is rated at a Level 1 capability. The process is

performed with no automation and information is not exchanged efficiently throughout the process. There are few standards enforced in this process.

Figure 3: Current Maturity Levels by Dimension: Manage RI Medicaid Business Relationship



Examples of the qualities and characteristics that support these ratings include the following:

- Communication with business partners is not automated
- Responses to questions are handled via phone or email
- Program areas implement their own communication standards and practices independently

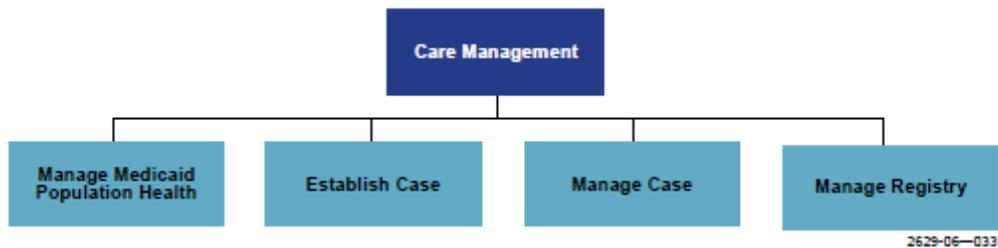
Table 2: Assessed Maturity Level by MITA Quality: Manage RI Medicaid Business Relationship

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.	1
Data Access & Accuracy	1
Mix of manual and automated processes. (This business process is completely manual at this time.)	1

MITA BCM Qualities & Characteristics	Level
Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI. (There is no EDI of any type at this time.)	1
There is no single standard for data stored for different types of data (eg, types of providers). (IAs are currently stored as MS Word or .PDF documents on a shared server.)	N/A
Staff researches, maintains, and responds to information requests manually.	1
Customers have difficulty accessing consistent, quality, or complete information (e.g., about programs or services).	N/A
Program areas require different rules / criteria and access points for similar business functions.	N/A
Effort to Perform	1
Updates are completed (keyed) manually.	1
Cost Effectiveness	1
Large number of staff required to perform business process. (Relative to RI.)	1
Accuracy of Process	1
Inconsistent decision making/validation..	1
Utility or Value to Stakeholders	1
Focus is on conducting business functions as efficiently as possible.	1

4 CARE MANAGEMENT

There are four business processes defined within the MITA framework for Care Management.



The RI Medicaid program performs two of the defined business processes:

- Manage Medicaid Population Health
- Manage Case

The following MITA Business Processes are not performed by RI:

- Establish Case – Covered in Establish Care Plan (Operations Management)
- Manage Registry – No applicable to RI Medicaid. KidsNet is outside of the Medicaid program.

4.1 Manage Case

4.1.1 MITA Business Process

Tier 2: Manage Case	
Item	Details
Description	<p>The Care Management Manage Case business process uses State-specific criteria and rules to ensure appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as:</p> <ul style="list-style-type: none"> ■ Medicaid Waiver program case management ■ Home and Community-Based Services ■ Other agency programs ■ Disease management ■ Catastrophic cases ■ Early Periodic Screening, Diagnosis, and Treatment (EPSDT) <p>These are individuals whose cases and treatment plans have been established in the Establish Case business process.</p> <p>It includes activities to confirm delivery of services and compliance with the plan. Also includes activities such as:</p> <ul style="list-style-type: none"> ■ Service planning and coordination ■ Brokering of services (finding providers, establishing limits or maximums, etc.) ■ Facilitating/Advocating for the member ■ Monitoring and reassessment of services for need and cost effectiveness. This includes assessing the member's placement and the services being received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs.

4.1.2 RI Business Process Overview

The Manage Case business process is performed by the following departments:

- The Office of Medical Review (OMR) of the Department of Human Services (DHS)
- The LTC Field Offices within the Department of Human Services (DHS)

- The Division of Development Disabilities (DDD) of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)
- The Department of Elderly Adults (DEA)
- The Department of Children, Youth and Families (DCYF)

These departments work collaboratively with Case Management Agencies throughout the State in maintaining up-to-date assessments and evaluations necessary for establishing clinical eligibility for services, participating in the care planning process and monitoring client progress in meeting the goals and objectives of the plan.

4.1.3 Business Process Variations

The MITA Business Process Model (BPM) for this function is incomplete. A version of this BPM has been created for Rhode Island Medicaid.

4.1.4 Systems and Datasets

The major systems and datasets that store, transact or exchange data in support of the authorize care plan process include:

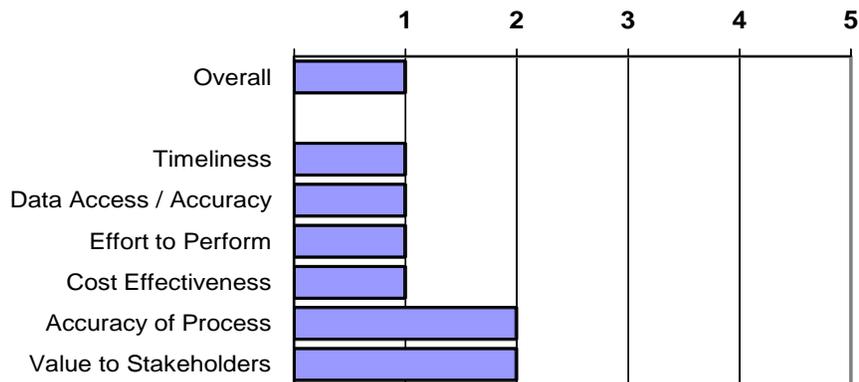
- CSM – (Community Supports Management) is a system used for managing long-term care clinical eligibility and care management functions
- CDM – (Consumer Direction Module) is system used to communicate among the participant, support broker, financial management services agency and state administrator simple and efficient and to permit ongoing, timely, and efficient monitoring for the Personal Choice Waiver.
- Omar – Web-based software used by the OMR's RNs for clinical level of care assessments as defined by the Global Waiver eligibility rules.
- RI MMIS – support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

- InRhodes – State’s Medicaid Eligibility system
- SAMS – Social Assistance Management System utilized by adult day services providers and providers of case management services. SAMS supplies client and service delivery data vital to tracking service delivery and to monitoring and evaluating home and community care programs
- RICHIST - The Rhode Island Children’s Information System (RICHIST) used by DCYF to administer Foster Care, Adoption, Juvenile Justice, Child Protective Services, Independent Living, Interstate Compact, Family Preservation and Support, Child and Family Services, Provider Services. RICHIST interfaces with the State Accounting System, InRHODES and the MMIS.

4.1.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of this business process are rated at a Level 1 capability. This Business Process performs many of its duties with very little automation and does not exchange information efficiently throughout the process.

Figure 4 Current Maturity Levels by Dimension: Manage Case



Examples of the qualities and characteristics that support these ratings include the following:

- Process requires manual chart review
- All communication with providers, beneficiaries, and case managers is performed manually via phone, fax, and letters
- Data are keyed manually into CDM, CSM and OMAR
- Case Management systems do not exchange data with each other
- CSM does communicate directly with InRhodes for eligibility purposes

Table 3 Assessed Maturity Level by MITA Quality: Manage Case

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.	1
Data Access & Accuracy	1
Mix of manual and automated processes.	1
Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI. Automation increases accuracy of data.	2
Records for different programs continue to be stored separately but can be accessed and aggregated as needed.	2
Staff researches, maintains, and responds to information requests manually.	1
Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.	2
Program areas require different rules / criteria and access points for similar business functions.	1
Effort to Perform	1
Updates are completed (keyed) manually.	1
Cost Effectiveness	1

MITA BCM Qualities & Characteristics	Level
Large number of staff required to perform business process. (Relative to RI)	1
Accuracy of Process	2
More consistency in decision making/rules / validation.	2
Utility or Value to Stakeholders	2
Automation and coordination processes enable staff to focus more on member and provider management.	2

4.2 Manage RI Medicaid Population Health

4.2.1 MITA Business Process

Tier 2: Manage Medicaid Population Health	
Item	Details
Description	<p>This business process designs and implements strategy 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. This business process outputs materials for:</p> <ul style="list-style-type: none"> ■ Campaigns to enroll new members in existing program ■ New program areas, services, etc. ■ Updated Benefits/Reference , Member , Provider <p>Communications with Impacted Members, Providers, and Contractors (e.g., program strategies and materials, etc.)</p>

4.2.2 RI Business Process Overview

The Manage RI Medicaid Population Health Business Process is overseen by the DHS in collaboration with the DEA, BHDDH, DCYF and DOH. This business process designs and implements strategies to improve the general health of the Medicaid population by targeting individuals by cultural, diagnostic or other demographic indicators.

4.2.3 Business Process Variations

The MITA Business Process Model (BPM) for this function is incomplete. A version of this BPM has been created for Rhode Island Medicaid.

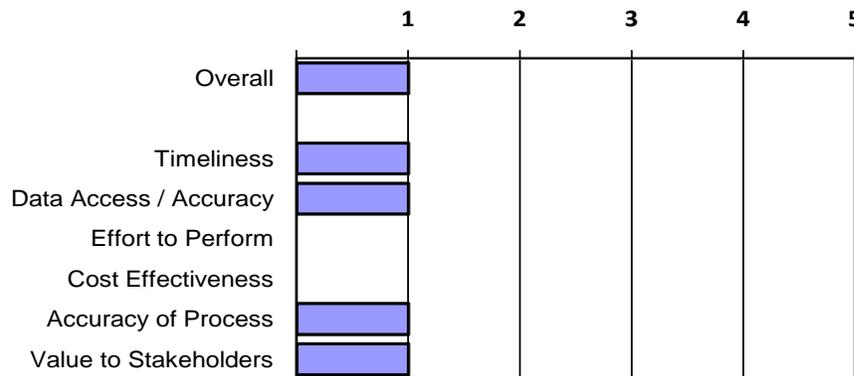
4.2.4 Systems and Datasets

Manage RI Medicaid Population Health is a manual process not supported by a major RI Medicaid systems.

4.2.5 Maturity Characteristics

As shown in below, all aspects of the Manage RI Medicaid Population Health are rated at a Level 1 capability. Several maturity characteristics are not applicable due to the minimal resources applied to this business process

Figure 5 Current Maturity Levels by Dimension: Manage RI Medicaid Population Health



Examples of the qualities and characteristics that support these ratings include the following:

- There are no formal data exchanges supporting this process
- There are a few guidelines governing the workflow
- Outcomes and decisions may take several months

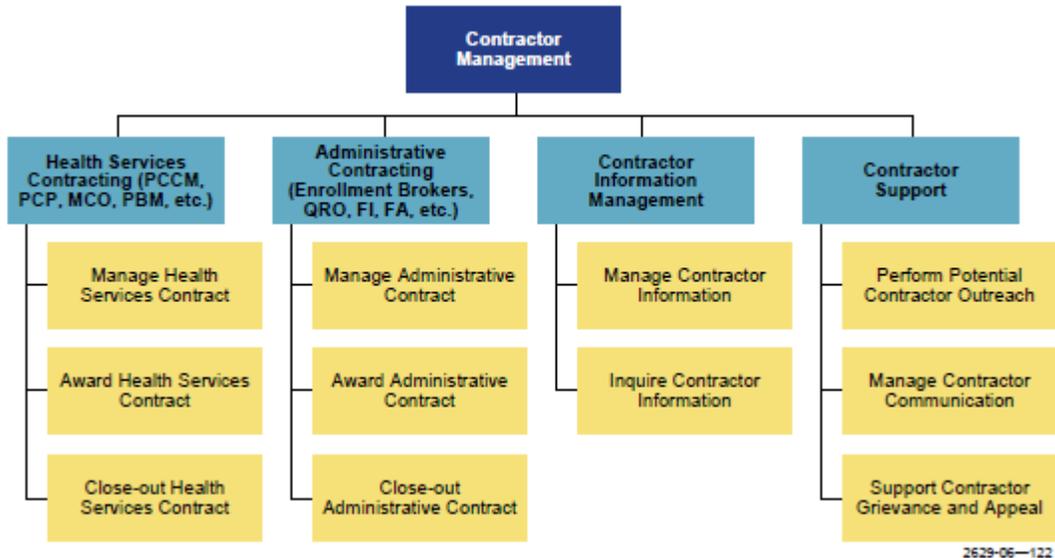
Table 4 Assessed Maturity Level by MITA Quality: Manage RI Medicaid Population Health

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days. Time lapse of process is within agency, state and federal guidelines	1
Data Access & Accuracy	1

MITA BCM Qualities & Characteristics	Level
Mix of manual and automated processes	1
Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI.	1
There is no single standard for data stored... (The data currently captured or stored to support this business process is minimal)	N/A
Staff researches, maintains and responds to information requests manually.	1
Customers have difficulty accessing consistent, quality or complete information...	1
Effort to Perform	N/A
Updates are completed (keyed) manually. (The data currently captured or stored to support this business process is minimal)	N/A
Cost Effectiveness	N/A
Large Number of staff required to perform business process (There are few staff currently applied to support this business process)	N/A
Accuracy of Process	1
Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently...	1
Utility or Value to Stakeholders	1
Focus is on conducting business functions as efficiently as possible	1

5 CONTRACTOR MANAGEMENT

There are eleven business processes defined within the MITA framework for Contractor Management.



The RI Medicaid program performs ten of the defined business processes:

- Award Administrative Contract / Award Health Services Contract
- Close-out Administrative Contract / Close out Health Services Contract
- Inquire Contractor Information
- Manage Administrative Contract / Manage Health Services Contracting
- Manage Contractor Information
- Perform Potential Contractor Outreach
- Support Contractor Grievance and Appeal

The following MITA Business Process is not performed by RI:

- Manage Contractor Communication – no formal process exists.

5.1 Award Administrative/Health Services Contract

5.1.1 MITA Business Process

Tier 3: Award health Service Contract	
Item	Details
Description	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.
Tier 3: Award Administrative Contract	
Item	Details
Description	<p>The Award Administrative Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses.</p> <p>Administrative services include: fiscal agent, managed care enrollment broker, professional services review, authorization for services, fraud detection, third party recovery, and many other outsourced services.</p>

5.1.2 RI Business Process Overview

The Award Administrative/Health Services Contract business process is overseen primarily by DHS and Department of Administration (Division of Purchases). The Division of Purchases oversees the entire procurement while DHS is responsible for the execution of the final contract. In addition, The Division of Purchasing streamlines the process to ensure vendors pursuing State contracts have fair and equitable opportunity. The Division is responsible for improving the procurement process by providing education for State employees and vendors doing business with the State.

The Award Administrative/Health Services Contract process covers various types of contracts utilized within the Medicaid program:

- MMIS Fiscal Agent
- Admission Screenings (PASRR)
- Managed Care Organizations (MCO)

- Primary Care Case Management (PCCM)
- Non-Emergency Transportation (primarily sole source)
- Agencies that provide Case Management

5.1.3 Business Process Variations

The following are examples of elements in this business process that diverge from the MITA definition:

- The Division of Purchases evaluates the RFP (This is an additional step then what is addressed in the MITA Business Process steps)
- Receive internal (state) and federal approvals for RFP (RFPs generally do not require CMS approval. CMS approval is done for the APD).
- Evaluate and score bids (this is an additional step performed by RI that is not included in the MITA framework)
- Issue Letter of Intent (this is an additional step performed by RI that is not included in the MITA framework)

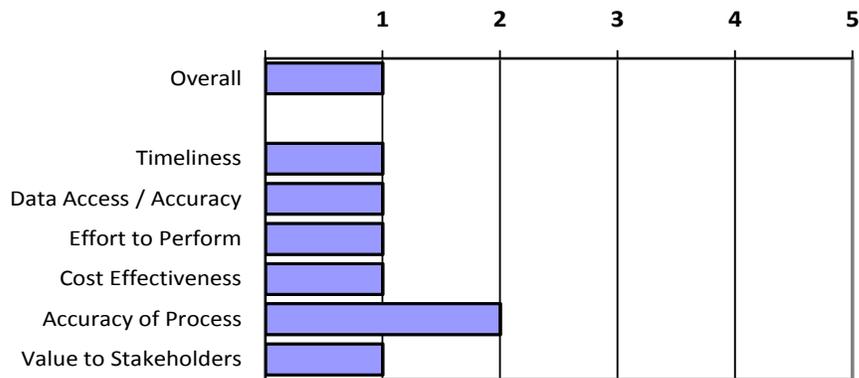
5.1.4 Systems and Datasets

The Award Administrative/Health Services Contract is a manual process not supported by any of the major RI systems.

5.1.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Award Administrative/Health Services Contract business process are rated at a Level 1 capability. The Award Administrative/Health Services Contract business process is performed with some automation, but does not exchange information efficiently throughout the process.

Figure 6 Current Maturity Levels by Dimension: Award Administrative/Health Services Contract



Examples of the qualities and characteristics that support these ratings include the following:

- Many steps performed are manual
- Applications are submitted on paper
- Requires a large number of staff
- Application format are relatively standardized

Table 5 Assessed Maturity Level by MITA Quality: Award Administrative/Health Services Contract

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days.	1
Data Access & Accuracy	1
At this level, the Award Administrative Contract business process uses application data that is standardized within the state.	2
Contractors submit applications via paper.	1
Effort to Perform	1
Much of the information is manually validated.	1

MITA BCM Qualities & Characteristics	Level
Staff contact external and internal document verification sources via phone, fax.	1
Services for the following steps and can be shared. Verify Credentials Verify ID Assign ID Assign Rates Negotiate Contract (Level 3 Only)	N/A
Cost Effectiveness	1
Requires large numbers of staff.	1
Accuracy of Process	2
Consistency is improved.	2
Utility or Value to Stakeholders	1
Business process complies with agency and state requirements.	1

5.2 Close-out Administrative/Health Services Contract

5.2.1 MITA Business Process

Tier 3: Close-out Health Services Contract	
Item	Details
Description	The Close-out Health Care 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.
Tier 1: Close-out Administrative Contract	
Item	Details
Description	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.

5.2.2 RI Business Process Overview

The Close-Out Administrative/Health Services Contract business process is overseen by the DHS. Close-out of contract terms is done by the divisions responsible for their services. For example, DHS Child and Family Services recently performed extensive close-out activities for a MCO contract.

The Close-Out Administrative/Health Services Contract process covers various types of contracts utilized within the Medicaid program:

- MMIS Fiscal Agent
- Admission Screenings (PASRR)
- Managed Care Organizations (MCO)
- Non-Emergency Transportation (primarily sole source)
- Case Management

5.2.3 Business Process Variations

The following are examples of elements in this business process that diverge from the MITA definition:

- Create a formal transition plan (this step is not defined in the MITA framework but done by the state)

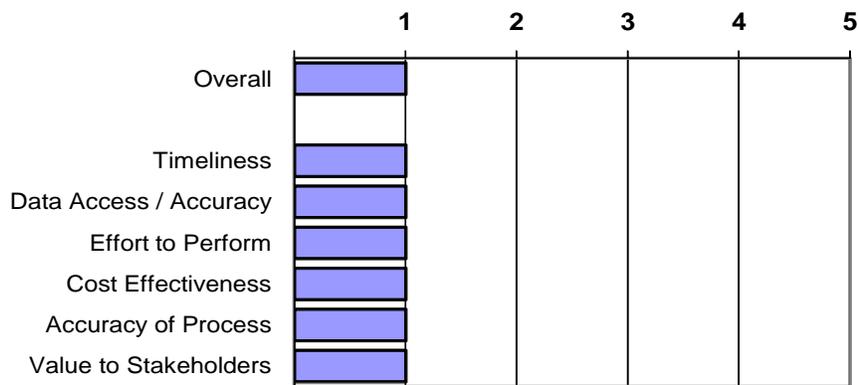
5.2.4 Systems and Datasets

The Close-Out Administrative/Health Services Contract is a manual process not supported by any of the major RI systems.

5.2.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Close-Out Administrative/Health Services Contract business process are rated at a Level 1 capability.

Figure 7: Current Maturity Levels by Dimension: Close-Out Administrative Contract



Examples of the qualities and characteristics that support these ratings include the following:

- Many steps performed are manual

- The process is predominately paper-based
- Each type of contract may be handled differently

Table 6: Assessed Maturity Level by MITA Quality: Close-Out Administrative/Health Services Contract

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Inconsistent timing for response to primary client	1
Data Access & Accuracy	1
At this level, the Close-out Administrative Contract business process uses indeterminate connectivity to client	1
Internal and external inputs and outputs are received or sent manually via paper, telephone and fax.	1
Effort to Perform	1
Verification is manual and if difficult then may require a longer amount of time.	1
Cost Effectiveness	1
Requires large number of staff	1
Accuracy of Process	1
Decisions may be inconsistent	1
Utility or Value to Stakeholders	1
Business process complies with agency and state requirements	1

5.3 Manage Administrative/Health Services Contract

5.3.1 MITA Business Process

Tier 3: Manage Health Services Contract	
Item	Details
Description	<p>The Manage Health Services Contract business process gathers requirements, develops a Request for Proposals, requests and receives approvals for the RFP, and solicits responses.</p> <p>Health care services include: medical care services, pharmacy benefits, dental benefits, mental health benefits, primary care services, and health care services outsourced to health insurance programs.</p>
Tier 1: Manage Administrative Contract	
Item	Details
Description	<p>The Monitor 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 contract throughout its duration.</p>

5.3.2 RI Business Process Overview

The Manage Administrative/Health Services Contract business process is overseen primarily by the DHS. The monitoring of contract terms is done by the divisions responsible for their services. Child and Family Services performs extensive monitoring of the MCO contracts on an ongoing and regular basis.

The Manage Administrative/Health Services Contract process covers various types of contracts utilized within the Medicaid program:

- MMIS Fiscal Agent
- Admission Screenings (PASRR)
- Managed Care Organizations (MCO)
- Non-Emergency Transportation (primarily sole source)
- Case Management

5.3.3 Business Process Variations

The following are examples of elements in this business process that diverge from the MITA definition:

- Determine if outside vendor is needed to assist in RFP requirements development (this step is not defined in the MITA framework but done by the state)

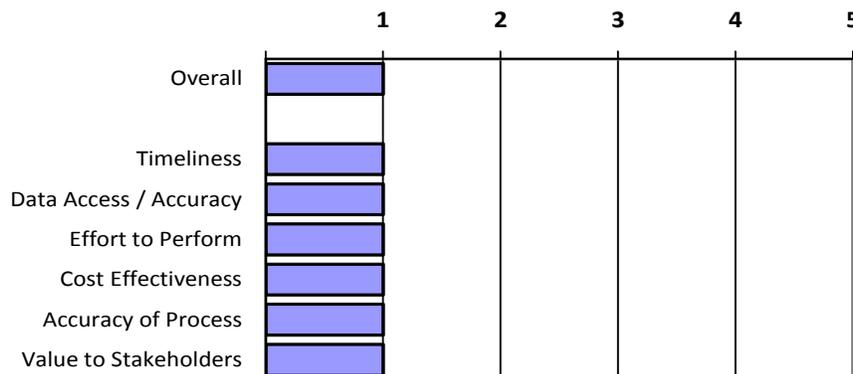
5.3.4 Systems and Datasets

The Manage Administrative/Heath Services Contract is a manual process not supported by any of the major RI systems.

5.3.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage Administrative/Heath Services Contract business process are rated at a Level 1 capability. The Manage Administrative Contract business process is performed with some automation, but does not exchange information efficiently throughout the process.

Figure 8: Current Maturity Levels by Dimension: Manage Administrative/Heath Services Contract



Examples of the qualities and characteristics that support these ratings include the following:

- Many steps performed are manual and predominately paper-based
- Expiration of contracts does not trigger an automatic message to initiate procurement process
- Programs may operate in silos in a non-standardized manner

Table 7: Assessed Maturity Level by MITA Quality: Manage Administrative/Health Services Contract

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days.	1
Data Access & Accuracy	1
At this level, the Manage Administrative Contract business process uses indeterminate format for application data.	1
Contractors submit applications via paper.	1
Services for the following steps and can be shared. Verify Credentials Verify ID Assign ID Assign Rates Negotiate Contract (Level 3 Only)	N/A
Effort to Perform	1
Much of the information is manually validated.	1
Staff contact external and internal document verification sources via phone, fax.	1
Cost Effectiveness	1
Requires large numbers of staff.	1
Accuracy of Process	1
Decisions may be inconsistent.	1
Utility or Value to Stakeholders	1
Business process complies with agency and state requirements.	1

5.4 Inquire Contractor Information

5.4.1 MITA Business Process

Tier 3: Inquire Contractor Information	
Item	Details
Description	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.

5.4.2 RI Business Process Overview

The Inquire Contractor Information business process is overseen by the DHS. DHS is responsible for receiving and responding to internal and external inquiries. DHS may receive inquires via phone, email letter, etc. Administrative staff review and investigate the merit of the inquiry and prepare a response. There is no formal process and inquires are not tracked.

The Inquire Contractor Information process covers various types of contracts utilized within the Medicaid program:

- MMIS Fiscal Agent
- Admission Screenings (PASRR)
- Managed Care Organizations (MCO)
- Non-Emergency Transportation (primarily sole source)
- Case Management

5.4.3 Business Process Variations

The following are examples of elements in this business process that diverge from the MITA definition:

- Query Contractor Registry for requested information (RI does not have a contractor registry. Contracts are kept in MS Word document on the network).
- Log Response (inquiries and responses are not logged).

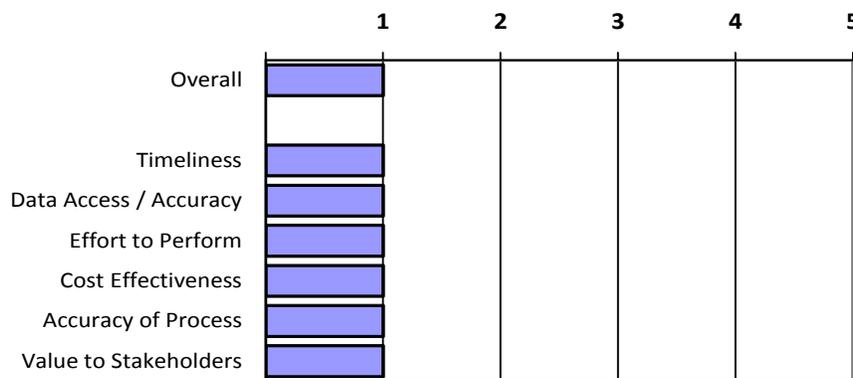
5.4.4 Systems and Datasets

The Inquire Contractor Information is a manual process not supported by any of the major RI systems.

5.4.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Inquire Contractor Information business process are rated at a Level 1 capability.

Figure 9: Current Maturity Levels by Dimension: Inquire Contractor Information



Examples of the qualities and characteristics that support these ratings include the following:

- Many steps performed are manual
- The process is predominately paper-based
- Each type of contract may be handled differently

Table 8: Assessed Maturity Level by MITA Quality: Inquire Contractor Information

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.	1
Data Access & Accuracy	1
Mix of manual and automated processes	1
Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI	1
There is no single standard for data stored for different types of data	1
Staff researches, maintains, and responds to information requests manually.	1
Customers have difficulty accessing consistent, quality, or complete information (e.g., about programs or services).	1
Program areas require different rules / criteria and access points for similar business functions.	1
Effort to Perform	1
Updates are completed (keyed) manually.	1
Cost Effectiveness	1
Requires large number of staff required to perform business process.	1
Accuracy of Process	1
Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and information quality and completeness.	1
Utility or Value to Stakeholders	1
Focus is on conducting business process as efficiently as possible.	1

5.5 Manage Contractor Information

5.5.1 MITA Business Process

Tier 3: Manage Contractor Information	
Item	Details
Description	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.

5.5.2 RI Business Process Overview

The Manage Contractor Information business process is overseen by the DHS. DHS is responsible for maintaining contract information. There is no formal process and a formal contractor registry does not exist.

The Manage Contractor Information process covers various types of contracts utilized within the Medicaid program:

- MMIS Fiscal Agent
- Admission Screenings (PASRR)
- Managed Care Organizations (MCO)
- Non-Emergency Transportation (primarily sole source)
- Case Management

5.5.3 Business Process Variations

The following are examples of elements in this business process that diverge from the MITA definition:

- Apply transaction to contractor data store (all contracts are maintained in MS Word documents. Updates are keyed manually)

- End. Report on action taken (there is no formal reporting process of updates to contracts).

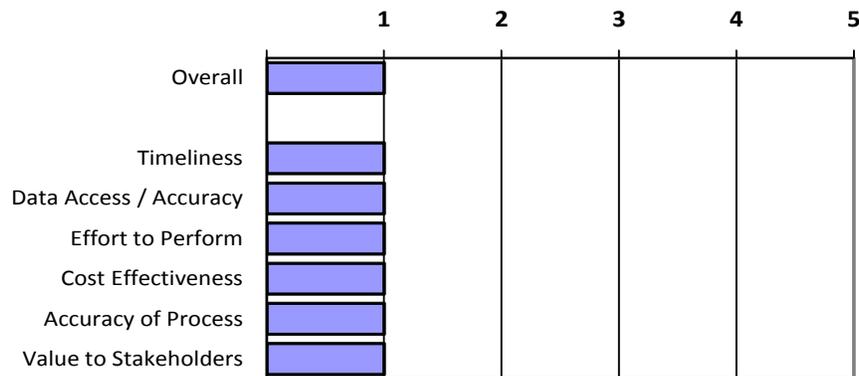
5.5.4 Systems and Datasets

The Manage Contractor Information is a manual process not supported by any of the major RI systems.

5.5.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage Contractor Information business process are rated at a Level 1 capability.

Figure 10: Current Maturity Levels by Dimension: Manage Contractor Information



Examples of the qualities and characteristics that support these ratings include the following:

- Many steps performed are manual
- The process is predominately paper-based
- Each type of contract may be handled differently
- Contractor registry does not exist

Table 9: Assessed Maturity Level by MITA Quality: Manage Contractor Information

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
There are delays in completing updates	1
Data Access & Accuracy	1
Requests are received from disparate sources in indeterminate formats	1
Irregular notification of change to users and processes that need to know	1
Effort to Perform	1
Updates are completed (keyed) manually.	1
Cost Effectiveness	1
Requires large number of staff required to perform business process.	1
Accuracy of Process	1
Validation is inconsistent and not rules-based	1
Duplicate entries may go undetected	
Utility or Value to Stakeholders	1
Business process complies with agency and state requirements	1

5.6 Perform Potential Contractor Outreach

5.6.1 MITA Business Process

Tier 2: Perform Potential Contractor Outreach	
Item	Details
Description	<p>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.</p> <p>For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs.</p> <p>For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives.</p> <p>Contractor outreach communications are distributed through various mediums via the Send Outbound 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.</p>

5.6.2 RI Business Process Overview

The Perform Potential Contractor Outreach business process is overseen primarily by the DHS program areas. Generally, DHS with approval the Division of Purchases publish Request for Information (RFI) as their venue for contractor outreach. Although other Divisions throughout the Department may undertake contractor outreach informally, the Division of Purchases offers outreach assistance for programs requiring procurement support.

5.6.3 Business Process Variations

The following are examples of elements in this business process that diverge from the MITA definition:

- Develop Request for Information (RFI) for the health care services (This step is not included in the MITA definition but performed by RI when

applicable. Not all contracts require an RFI – some procurements may release a Request for Proposal (RFP) and may be open to any eligible vendors meeting the contract requirement.)

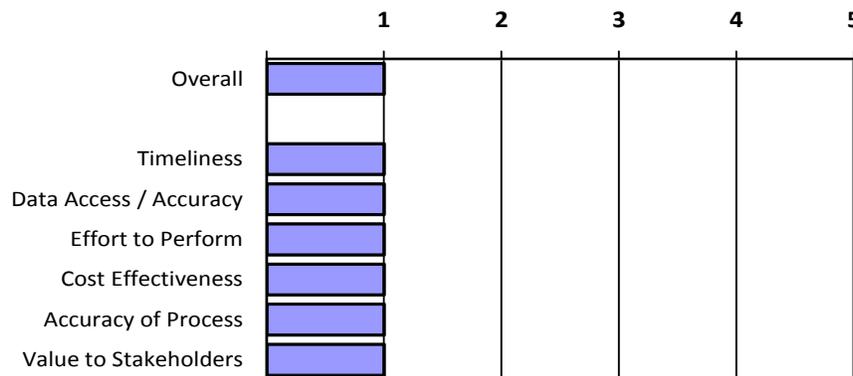
5.6.4 Systems and Datasets

Perform Potential Contractor Outreach is a manual process. RFI document are published on State websites, news papers and other mediums. Data does not interface with the MMIS.

5.6.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Perform Potential Contractor Outreach Overall business process is rated at a Level 1 capability. The Perform Potential Contractor Outreach business process performs many of its duties with very little automation and uses various silos of information to support the business process.

Figure 11: Current Maturity Levels by Dimension: Perform RI Medicaid Potential Contractor Outreach



Examples of the qualities and characteristics that support these ratings include the following:

- Contractor outreach may be performed via the internet

- Contact data are not standardized among various entities that support DHS procurement activities
- Little emphasis on linguistic or cultural considerations

Table 10: Assessed Maturity Level by MITA Quality: Perform Potential Contractor Outreach

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days.	1
Data Access & Accuracy	1
At this level, the Perform Potential Contractor Outreach process primarily conducted via paper and phone. However, states use Websites ... to distribute information to targeted contractors.	2
Contact data is not standardized.	1
Outreach may be more coordinated because programs are able to share analysis/performance measures based on increased standardization of administrative data ... and improved data manipulation for decision support.	2
Effort to Perform	1
Materials can be posted on a Web site for downloading by contractor.	1
Cost Effectiveness	1
Paper communication is costly.	1
Accuracy of Process	1
More standardization and consistency in targeting populations.	1
Utility or Value to Stakeholders	1
No emphasis on linguistic, cultural or competency-based considerations.	1

5.7 Support Contractor Grievance and Appeal

5.7.1 MITA Business Process

Tier 2: Support Contractor Grievance and Appeal	
Item	Details
Description	<p>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.</p> <p>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.</p> <p>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.</p> <p>NOTE: States may define “grievance” and “appeal” differently, perhaps because of state laws.</p> <p>*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.</p>

5.7.2 RI Business Process Overview

The Support Contractor Grievance and Appeal business process is overseen by the DHS. DHS has interagency agreements with the Division of Legal Services to handle disputes for RI Medicaid providers. The appeal process is documented and made available to potential contractors.

The Support Contractor Grievance and Appeal process covers various types of contracts utilized within the Medicaid program:

- MMIS Fiscal Agent

- Admission Screenings (PASRR)
- Managed Care Organizations (MCO)
- Non-Emergency Transportation (primarily sole source)
- Case Management

5.7.3 Business Process Variations

The Support Contractor Grievance and Appeal business process does not significantly diverge from the MITA business process definition.

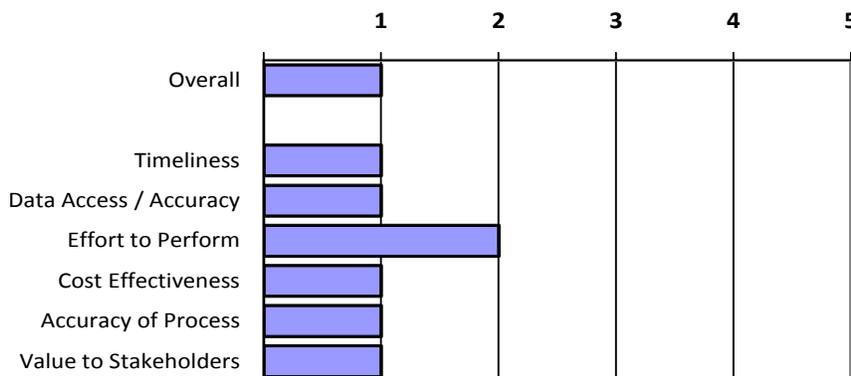
5.7.4 Systems and Datasets

The Support Contractor Grievance and Appeal business process is a manual process not supported by any of the major RI systems.

5.7.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Support Contractor Grievance and Appeal business process are rated at a Level 1 capability with the exception of Effort to Perform rated at a Level 2.

Figure 12: Current Maturity Levels by Dimension: Support Contractor Grievance and Appeal



Examples of the qualities and characteristics that support these ratings include the following:

- Many steps performed are manual
- The process is predominately paper-based
- Decisions may take several days

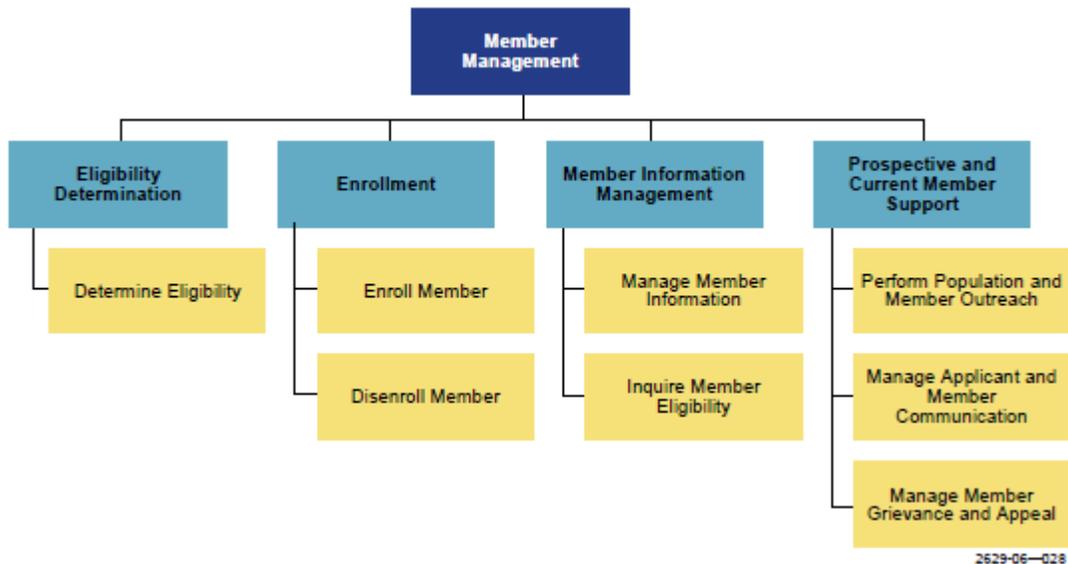
Table 11: Assessed Maturity Level by MITA Quality: Support Contractor Grievance and Appeal

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions may take several days	1
Data Access & Accuracy	1
At this level, the Support Grievance and Appeal process is entirely paper based, which results in poor document management and process inefficiencies that impact timelines	1
Agencies begin to centralize or standardize the administration of this process to achieve economies of scale, thereby increasing administrative policies and inhibiting performance monitoring	2
Effort to Perform	2
Internal review and information gathering must be conducted by phone or in person.	2
The process supports the Program Quality Management business area...(level 3 only).	N/A
Cost Effectiveness	1
Process is labor intensive. Results take several months	1
Accuracy of Process	1
Terms of the settlement or results of the hearing are manually documented according to the administrative rules of the state	1
Communications are more consistent	2
Utility or Value to Stakeholders	1

MITA BCM Qualities & Characteristics	Level
Provider may have difficulty: Finding the "Right Door" Accessing Program rules Getting assistance on their case Receiving consistent responses or communications that are linguistically, culturally and competency appropriate	1

6 MEMBER MANAGEMENT

There are eight business processes defined within the MITA framework for Member Management.



The RI Medicaid program performs all of the defined business processes, with Determine Eligibility performed differently for different programs:

- Determine Eligibility
- Disenroll Member
- Enroll Member
- Inquire Member Eligibility
- Manage Applicant and Member Communication
- Manage Member Grievance and Appeal
- Manage Member Information
- Manage Member Information

- Perform Population and Member Outreach

6.1 Determine RI Medicaid Eligibility

6.1.1 MITA Business Process

Tier 3: Determine Eligibility	
Item	Details
Description	<p>The Determine Eligibility business process 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. See Attachment A for details associated with specific groups of eligibility, i.e., Children and Parents, Disabled, Elderly.</p> <p>NOTE: A majority of 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>

6.1.2 RI Business Process Overview

The Determine RI Medicaid Eligibility process is overseen by DHS. Applicants are required to complete a paper application available at the county field offices. Case workers are available for assistance with the application process or completed applications can be dropped off for review. The case worker will then meet with each applicant to review supporting documentation and discuss available programs which the applicant may be eligible for. This face-to-face meeting is not required for the Rite Care managed care program.

Once the applicant is determined eligible they are enrolled in the Fee-For-Service (FFS) program and assigned a Medicaid eligibility category (i.e. Katie Beckett) within

InRhodes. There is a nightly batch process that sends eligibility information to the MMIS eligibility subsystem.

The Breast and Cervical Cancer Treatment Program (BCCTP) eligibility determination process is assessed separately and manually entered into InRhodes once eligibility determination has been made. See the Determine BCCTP Eligibility business process.

The Respite Care for Children eligibility determination process is assessed separately and manually entered into InRhodes once eligibility determination has been made. See the Determine Respite Care for Children Eligibility business process.

6.1.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Verify Other Coverage – Validate information supplied by applicant; verify with other coverage sources not referenced by applicant (other coverage information is gathered and accepted from the applicant without further verification).
- For Elderly Applicants, verify the following...(this step is performed by the LTC field offices utilizing the CSM program. Clinical eligibility is determined separately after Medicaid eligibility has been established. See the Establish Core Level of Care Plan write-up for clinical eligibility).
- For Disabled Applicants, Verify Disability – Determine that applicant meets disability qualifications...(for the Katie Beckett eligibility category, a special medical review team handles this verification. Application is put on hold for up to 90 days while this is completed).
- Determine Other Eligibility Categories — Identify other eligibility categories for which applicant may be eligible and determine hierarchy of applicability in the case of multiple eligibilities; this includes eligibility for other programs, e.g., Disability, Veterans Administration, Indian Health

Service (eligibility for other non-Medicaid programs is not determined but the applicant may be referred to apply elsewhere)

- Associate Benefit Packages (RI utilizes the Eligibility Category to determine approved services).

6.1.4 Systems and Datasets

The major systems and datasets that store, transact or exchange data in support of the Determine RI Medicaid Eligibility process include:

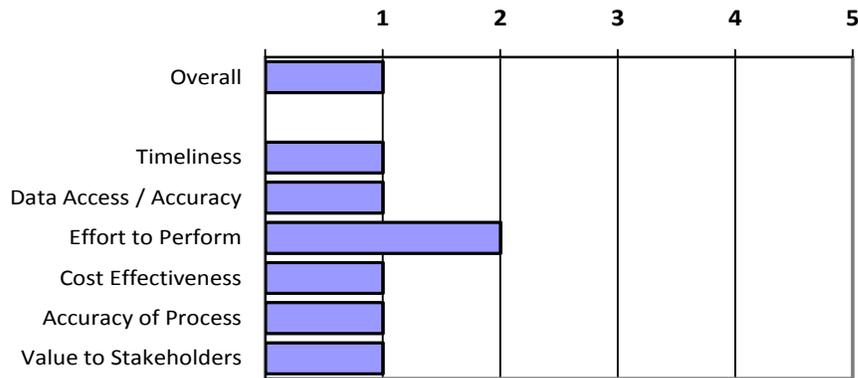
- InRhodes – the state’s eligibility system used for determination and enrollment information.
- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- CSM - Community Supports Management (CSM) system for managing long-term care clinical eligibility and care management functions.
- NEW HIRE - An interface that provides information from the State Directory of New Hires about individuals who have been newly hired and their place of employment.
- State Wage Data Exchange Interface (SWICA) – A monthly file from the Department of Labor & Training (DLT) that determines whether the correct amount of earned income is reflected in the case with a matched SSN of an applicant during the eligibility determination process.
- Internal Revenue Service Interface (IRS) – A monthly interface that provides information about unearned income, specifically, interest and dividend income.

- SSA Wage Data Interface (WAGE) – A monthly interface that provides information on annual earnings.
- Unemployment Insurance Interface (UI) – A monthly interface that verifies the amount of UI benefits received by an applicant.
- Temporary Disability Insurance (TDI) – A monthly interface that determines whether the correct TDI amount is reflected in an applicant’s case file.
- State Verification and Eligibility System (SVES) – An interface to validate Social Security Numbers (SSNs).
- Prisoner Interface – A file that provides information from the Rhode Island Department of Corrections (DOC) and the Social Security Administration (SSA) concerning prison inmates.
- Income and Eligibility Verification System (IEVS) – An interface to compare benefit information and other data for the purpose of identifying unreported information.
- Public Assistance Reporting Information System (PARIS) –used to validate client reported circumstances and identify possible candidates for erroneous payments based on data provided.

6.1.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Determine RI Medicaid Eligibility process are rated at a Level 1 with the exception of effort to perform.

Figure 13 Current Maturity Levels by Dimension: Determine RI Medicaid Eligibility



Examples supporting these Determine RI Medicaid Eligibility process ratings include the following:

- Applications are paper-based and may be different depending upon eligibility category applying for (i.e. Katie Beckett and Adult Disabled utilize the DHS 1 and 2 forms)
- Waiver programs introduce flexibility and access to care
- Some information continues to be manually verified

Table 12 Assessed Maturity Level by MITA Quality: Determine RI Medicaid Eligibility

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions take several days.	1
Data Access & Accuracy	1
Determine Eligibility business process is extended by “work-arounds” to meet the needs of programs besides FFS.	2
The process is constrained by ... state eligibility system functionality.	1

MITA BCM Qualities & Characteristics	Level
Application data may be standardized within the state. Some efforts are made toward standardizing eligibility determination data so that it is more easily shared and compared.	2
Applications are paper only.	1
Eligibility determination may still occur in silos without sharing or coordination.	2
Benefit package selections may still be limited for traditional Medicaid programs. However, Waiver programs may be structured to permit more flexibility around selection of services and providers within a benefit package. (For RI, eligibility categories and program indicators are used for “benefit package” information).	2
Effort to Perform	2
There are many pathways for determining eligibility for low income applicants.	2
Transfers must be scheduled for batch transmission outside of production cycles, which impedes timely availability.	N/A
Spend-down continues to be calculated manually. (InRhodes does calculate spend down but a level 3 ratings requires the MMIS to automatically deduct spend down from claims payments until met. This is not done in RI).	2
Re-determination notices are automatically generated. (Level 4 only)	N/A
Cost Effectiveness	1
Requires large numbers of staff (relative for RI).	1
Accuracy of Process	1
Consistency [in decision-making] is improved.	2
When eligibility information is transferred ... to MMIS, it must be converted and data is lost. (Level 1 only)	N/A
Staff contact external and internal document verification sources via phone, fax. Information is manually validated.	1
Utility or Value to Stakeholders	1
Services and providers are selected without emphasis on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally appropriate, and functional.	1

6.2 Determine BCCTP Eligibility

6.2.1 MITA Business Process

Tier 3: Determine Eligibility	
Item	Details
Description	<p>The Determine Eligibility business process 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. See Attachment A for details associated with specific groups of eligibility, i.e., Children and Parents, Disabled, Elderly.</p> <p>NOTE: A majority of 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>

6.2.2 RI Business Process Overview

The Determine Breast and Cervical Cancer Treatment Program (BCCTP)

Eligibility program is overseen by the Department of Health (DOH) and verified by DHS. The DOH conducts free screenings and provides an application for the BCCTP based upon results. The DOH verifies income eligibility and sends application and all supporting documentation to the DHS for determination and enrollment into the program. Determination criteria is assessed manually, outside of InRhodes. Once approved, applicant information is entered into InRhodes and notification to applicant is done by hand written letters.

Once the Determine BCCTP Eligibility process is complete, the beneficiary is enrolled in the applicable Medicaid eligibility category (CD for pre-cancer, CA for cancer diagnosis). All pre-cancer applicants are defaulted to the Fee-For-Service (FFS)

program for 4 months until re-determination is made. All applicants with a valid cancer diagnosis are also defaulted to FFS for the standard one month and then enrolled into a Managed Care Plan. There is a nightly batch process that sends eligibility information to the MMIS eligibility subsystem.

This process has its own distinct set of functions from those separately assessed for Determine Medicaid Eligibility, which also maps to the MITA Determine Eligibility business process.

6.2.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Meet with applicant or member head of household as scheduled....Review member application and additional information provided by member in determination process....(DHS does not meet separately with BCCTP applicants. Applicants have already been seen by the DOH).
- Verify Income Eligibility (DOH has already verified income eligibility by the time the application is referred to DHS).
- For Spend-Down applicants, verify that qualifying medical care expenditures amount has been met (Spend down does not apply to the BCCTP).
- Verify Resource Eligibility (DOH has already verified income/resources for eligibility by the time the application is referred to DHS).
- For Elderly Applicants, verify the following....(N/A for BCCTP)
- For Disabled Applicants, Verify Disability.... Determine that applicant meets disability qualifications (N/A for BCCTP)
- For the Elderly, determine eligibility for QMB, SLMB (N/A for BCCTP)
- For Pregnant Women, Verify Pregnancy (N/A for BCCTP)

- Determine Other Eligibility Categories — Identify other eligibility categories for which applicant may be eligible and determine hierarchy of applicability in the case of multiple eligibilities; this includes eligibility for other programs, e.g., Disability, Veterans Administration, Indian Health Service (eligibility for other eligibility categories are not determined)
- Associate Benefit Packages (RI utilizes the Eligibility Category to determine approved services for BCCTP).
- Request that the Manage Applicant and Member Communication process generate notifications (all BCCTP notifications from DHS are hand-written letters).

6.2.4 Systems and Datasets

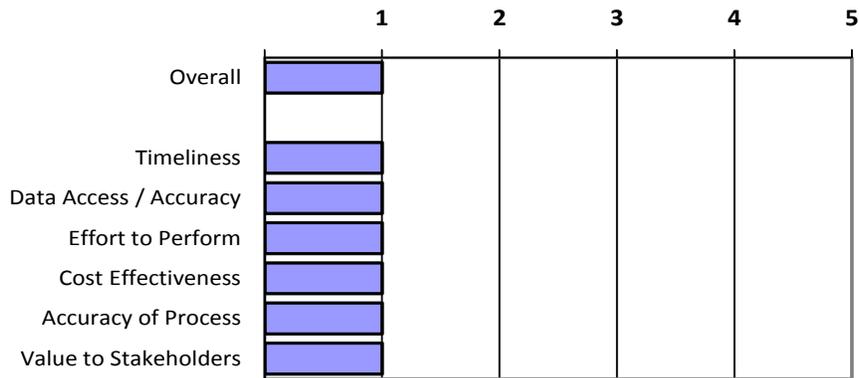
The major systems and datasets that store, transact or exchange data in support of the Determine BCCTP Eligibility process include:

- RI MMIS –RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state’s eligibility system used for Medicaid determination and enrollment information.
- Public Assistance Reporting Information System (PARIS) –used to validate client reported circumstances and identify possible candidates for erroneous payments based on data provided.

6.2.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Determine BCCTP Eligibility process are rated at a Level 1.

Figure 14 Current Maturity Levels by Dimension: Determine BCCTP Eligibility



Examples supporting these Determine BCCTP Eligibility process ratings include the following:

- BCCTP determination is done manually, outside of InRhodes
- Supporting documentation continues to be manually verified
- Process may take several days
- Communication to members is done by hand written letters

Table 13 Assessed Maturity Level by MITA Quality: Determine BCCTP Eligibility

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions take several days.	1
Data Access & Accuracy	1
Determine Eligibility business process is by extended by “work-arounds” to meet the needs of programs besides FFS.	2
The process is constrained by ... state eligibility system functionality.	1

MITA BCM Qualities & Characteristics	Level
Application data may be standardized within the state. Some efforts are made toward standardizing eligibility determination data so that it is more easily shared and compared.	2
Applications are paper only.	1
Eligibility determination may still occur in silos without sharing or coordination.	2
Benefit package selections may still be limited for traditional Medicaid programs. However, Waiver programs may be structured to permit more flexibility around selection of services and providers within a benefit package. (For RI, eligibility categories and program indicators are used for "benefit package" information).	2
Effort to Perform	1
There are many pathways for determining eligibility for low income applicants.	1
Transfers must be scheduled for batch transmission outside of production cycles, which impedes timely availability.	N/A
Spend-down amounts are calculated manually. (N/A for BCCTP)	N/A
Re-determination notices are automatically generated. (Level 4 only).	N/A
Cost Effectiveness	1
Requires large numbers of staff (relative for RI).	1
Accuracy of Process	1
Decisions may be inconsistent	1
When eligibility information is transferred ... to MMIS, it must be converted and data is lost. (Level 1 only)	N/A
Staff contact external and internal document verification sources via phone, fax. Information is manually validated.	1
Utility or Value to Stakeholders	1
Services and providers are selected without emphasis on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally appropriate, and functional.	1

6.3 Determine Respite Care For Children eligibility

6.3.1 MITA Business Process

Tier 3: Determine Eligibility	
Item	Details
Description	<p>The Determine Eligibility business process 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. See Attachment A for details associated with specific groups of eligibility, i.e., Children and Parents, Disabled, Elderly.</p> <p>NOTE: A majority of 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>

6.3.2 RI Business Process Overview

The Determine Respite Care for Children Eligibility process is overseen by DHS, Child and Family Services. Applicants are already enrolled in Medicaid. Paper application packets are submitted directly to DHS and reviewed for qualification.

Once the Determine Respite Care for Children Eligibility process is complete, the MMIS is updated with a program indicator for respite services. The state eligibility system, InRhodes, is not updated with Respite eligibility.

The Determine Respite Care for Children Eligibility process was assessed separately but also maps to the MITA Determine Eligibility definition.

6.3.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Meet with applicant or member head of household (this is not required for respite)
- Verify Income Eligibility (N/A for respite. Completed during Medicaid Determination)
- For Spend Down Applicants (N/A for respite. Completed during Medicaid Determination)
- Verify Immigration Status (N/A for respite. Completed during Medicaid Determination)
- Verify Residency (N/A for respite. Completed during Medicaid Determination)
- Verify Other Coverage (N/A for respite. Completed during Medicaid Determination)
- For Elderly Applicants, verify the following (N/A for respite.)
- For Other Elderly, determine eligibility for QMB, SLMB (N/A for respite)
- For Disabled Applicants, Verify Disability – Determine that applicant meets disability qualifications (N/A for respite. Completed during Medicaid Determination).
- For Pregnant Women, Verify Pregnancy (N/A for respite)
- Determine Other Eligibility (N/A for respite. Completed during Medicaid Determination)
- Associate Benefit Packages (RI utilizes the Eligibility Category to determine approved services).

6.3.4 Systems and Datasets

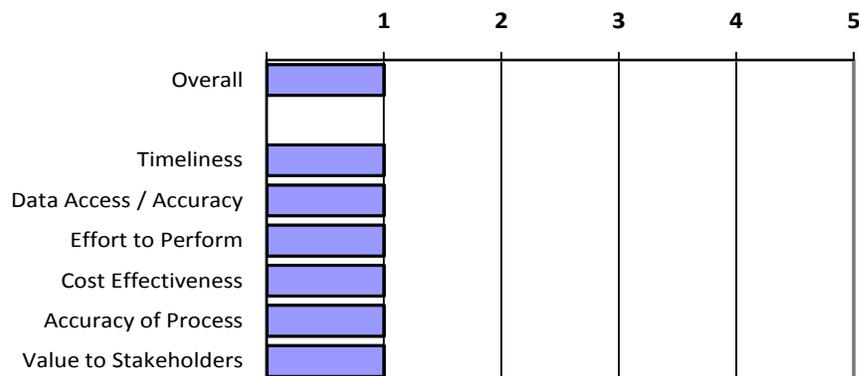
The major systems and datasets that store, transact or exchange data in support of the Determine Respite Care for Children Eligibility process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- CHCSN - A standalone access database used by programs for children with special needs.
- Public Assistance Reporting Information System (PARIS) –used to validate client reported circumstances and identify possible candidates for erroneous payments based on data provided.

6.3.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Determine Respite Care for Children Eligibility process are rated at a Level.

Figure 15 Current Maturity Levels by Dimension: Determine Respite Care for Children Eligibility



Examples supporting these Determine Respite Care for Children Eligibility process ratings include the following:

- Applications are paper-based and manually reviewed
- State’s eligibility system is not updated with respite enrollment
- Decisions can take several days

Table 14 Assessed Maturity Level by MITA Quality: Determine Respite Care for Children Eligibility

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions take several days.	1
Data Access & Accuracy	1
Determine Eligibility business process is extended by “work-arounds” to meet the needs of programs besides FFS.	2
The process is constrained by ... state eligibility system functionality.	1
Application data may be standardized within the state. Some efforts are made toward standardizing eligibility determination data so that it is more easily shared and compared.	2
Applications are paper only.	1
Eligibility determination may still occur in silos without sharing or coordination.	2
Benefit package selections may still be limited for traditional Medicaid programs. However, Waiver programs may be structured to permit more flexibility around selection of services and providers within a benefit package. (For RI, eligibility categories and program indicators are used for “benefit package” information).	2
Effort to Perform	1
There are many pathways for determining eligibility.	1
Transfers must be scheduled for batch transmission outside of production cycles, which impedes timely availability.	N/A
Spend-down continues to be calculated manually. (N/A for respite)	N/A
Re-determination notices are automatically generated. (Level 4 only)	N/A
Cost Effectiveness	1

MITA BCM Qualities & Characteristics	Level
Requires large numbers of staff (relative for RI).	1
Accuracy of Process	1
Consistency [in decision-making] is improved.	2
When eligibility information is transferred ... to MMIS, it must be converted and data is lost. (Level 1 only)	N/A
Staff contact external and internal document verification sources via phone, fax. Information is manually validated.	1
Utility or Value to Stakeholders	1
Services and providers are selected without emphasis on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally appropriate, and functional.	1

6.4 Enroll Managed Care Member

6.4.1 MITA Business Process

Tier 3: Enroll Member	
Item	Details
Description	The Enroll Member business process 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. See Attachment A for details associated with specific groups of eligibility, i.e., managed care, HIPP, waiver. NOTE: There is a separate business process for Disenroll Member.

6.4.2 RI Business Process Overview

The Enroll Managed Care Member process is overseen by DHS. Once applicants are determined to be Medicaid eligibility and defaulted to the FFS program, members are sent a letter informing them of requirement to enroll in a managed care plan (Rhody Health Partners, Rite Care, RiteSmiles, Connect Care Choice). Members fill out application for plan of their choice and return application to eligibility field office.

Once managed care plan enrollment application is received from member, InRhodes is updated with managed care plan and MCO is notified.

6.4.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Notify other eligibility systems (There are no other RI eligibility systems to notify. InRhodes nightly batch process updates the MMIS Eligibility subsystem)

6.4.4 Systems and Datasets

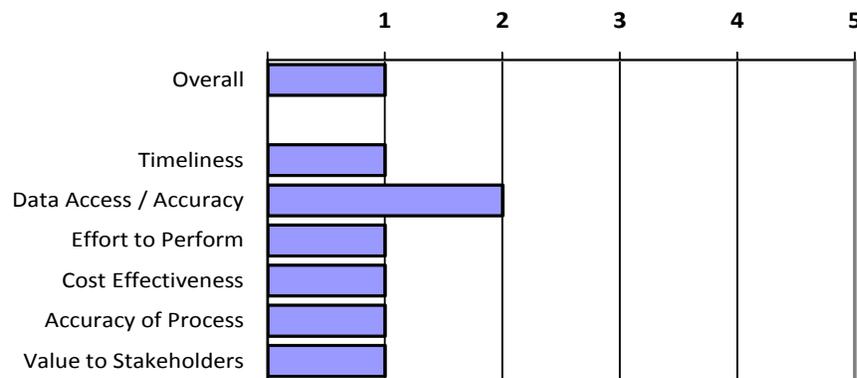
The major systems and datasets that store, transact or exchange data in support of the Enroll Managed Care Member process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state’s eligibility system used for determination and enrollment information.

6.4.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Enroll Managed Care Member process are rated at a Level 1 with the exception of Data Access / Accuracy rated at a Level 2.

Figure 16 Current Maturity Levels by Dimension: Enroll Managed Care Member



Examples supporting these Enroll Managed Care Member process ratings include the following:

- Applications are paper-based
- Some information continues to be manually verified
- Managed Care Organizations receive standardized 834 Enrollment Transactions

Table 15 Assessed Maturity Level by MITA Quality: Enroll Managed Care Member

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Decisions on application may take several days; longer if verification of information is difficult.	1
Contractors do not receive timely enrollment information. Staff must send paper enrollment notification to contractors. (Level 1 only).	N/A
Although data is electronic, much of the review and verification of information for waiver programs must be done manually. (Not applicable for Managed Care enrollment)	N/A
Managed care enrollment is rule driven and automated; applicants and members communicate via Web portal for increased timeliness. (Level 2 Only)	N/A
Data Access & Accuracy	2
Enrollment data are standardized within the agency.	2
Enrollment applications are standardized and electronic; ...HIPAA contractors receive standardized 834 Enrollment Transactions....	2
Enrollment records are stored in either a single member registry or federated Agency member registries that can be accessed by all applications. All member enrollment records are stored and accessible with service calls in the Medicaid member registry.	2
Providers, members, and state enrollment staff have secure access to appropriate and accurate data on demand.	3
Although data comparability is improved and supports use of performance measures to evaluate providers, performance data is only periodically measured and requires sampling and statistical calculation.	2
Notifications to contractors are state-specific and differ by contractor type. (Level 1 only)	N/A
Effort to Perform	1
Enrollment processes continue to be handled by siloed programs according to program-specific rules.	2
Staff makes decisions autonomously and without consultation with other programs.	1

MITA BCM Qualities & Characteristics	Level
Contractors and providers can query the registry to determine eligibility and program enrollment. Contractors may batch download enrolled members rather than receive the HIPAA 834. (Level 3 only)	N/A
Applicants and members can submit applications, make inquiries, and choose providers and MCOs on paper.	1
Applicants may submit applications online, but results are not real time. (Level 2 Only)	N/A
Verifications and enrollment are a mix of manual and automated steps.	2
Eligibility determination must precede enrollment and is done separately.	1
Services created for the enrollment process, including the Web application, the enrollment and verification interfaces, registry calls and synchronization mechanisms can be shared among states. (Level 3 Only)	N/A
Enrollment in managed care and waiver programs requires cumbersome extension of traditional fee-for-service processes.	1
If the provider's system is service enabled, it can prepopulate appropriate enrollment application(s) and to request additional information needed from the provider/applicant. (Level 4 Only)	N/A
Cost Effectiveness	1
Requires a large staff to meet targets for manual enrollment of members.	1
Fewer applicants and members are enrolled erroneously, reducing program costs.	2
Enrollment alerts to providers reduces staff needed for enrollment outreach and verification of health status. (Level 4 Only)	N/A
Accuracy of Process	1
Much of the application information is manually validated and verification may be difficult resulting in increase error rates and potential for fraud.	1
Decisions may be inconsistent.	1
Permits blending of program benefits to provide more appropriate services to members. (Level 2 Only)	N/A
Standardization of enrollment data, verification automation, business rules and workflow capabilities, and coordination across programs enable monitoring and reverification of enrolled members' status, reducing enrollment of ineligible members.	2
Use of standardized, electronic enrollment transactions somewhat improves accuracy of enrollment data exchange between MMIS and Contractor member registries....	2
Utility or Value to Stakeholders	1
Focus is on accurately processing enrollment and manually verifying information as efficiently as possible.	1

MITA BCM Qualities & Characteristics	Level
Staff does not have time to focus on health, functional, cultural and linguistic compatibility of provider or program for the member, or member satisfaction.	1

6.5 Disenroll RI Medicaid Member

6.5.1 MITA Business Process

Tier 3: Disenroll Member	
Item	Details
Description	<p>The Disenroll Member business process is responsible for managing the termination of a member’s enrollment in a program, including:</p> <ul style="list-style-type: none"> ■ Processing of eligibility terminations and requests for e.g., disenrollment – Submitted by the member, a program provider or contractor <ul style="list-style-type: none"> — 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 — As 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 — Mass Disenrollment due to termination of program provider or contractor ■ Validation that the termination meets state rules ■ Requesting that the Manage Member Information process load new and changed disenrollment information ■ 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 <ul style="list-style-type: none"> — The Capitation and Premium and Member Payment Management Areas business processes about changed Member Registry information for payment preparation — The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural Rights <p>Enrollment brokers may perform some of the steps in this process</p>

6.5.2 RI Business Process Overview

The Disenroll RI Medicaid Member process is overseen by DHS. The majority of disenrollment activity is a result of re-determination of Medicaid eligibility. Re-determination period is based upon the program/eligibility category (i.e. LTC is

annual, Medical Assistance is every six months, Katie Beckett non-clinical is annual with clinical re-determination based upon diagnosis and potential for improvement).

InRhodes does not contain separate disenrollment records, eligibility records are just closed with an end date.

6.5.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Assign unique identifier for tracking (this is not captured)
- Produce disenrollment record data set and request that the Manage Member Information process load the disenrollment record into Member Registry (N/A as disenrollment records are not created)
- End: Alert the appropriate Operations Management Area processes (InRhodes nightly batch process updates the MMIS Eligibility subsystem of closed eligibility for Capitation and Premium Payment processes. MCO is also notified).

6.5.4 Systems and Datasets

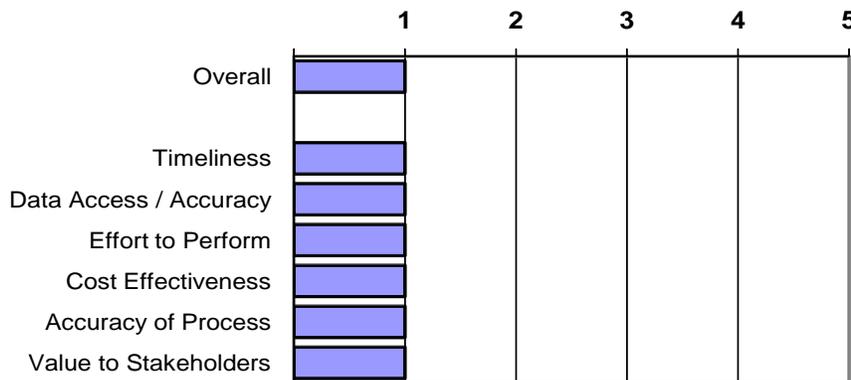
The major systems and datasets that store, transact or exchange data in support of the Disenroll RI Medicaid Member process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state’s eligibility system used for determination and enrollment information.

6.5.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Disenroll RI Medicaid Member process are rated at a Level 1.

Figure 17 Current Maturity Levels by Dimension: Disenroll RI Medicaid Member



Examples supporting these Disenroll RI Medicaid Member process ratings include the following:

- Information is researched manually
- Re-determination may take several months
- Information can be shared among authorized entities within the state

Table 16 Assessed Maturity Level by MITA Quality: Disenroll RI Medicaid Member

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Most requests to disenroll member are received and responded to manually via phone, fax, USPS. (re-determination process)	1
Responses to requests are immediate (only levels 2 – 5 are scored for this particular attribute).	N/A
Information can be shared among authorized entities within the state.	3

MITA BCM Qualities & Characteristics	Level
Data Access & Accuracy	1
Information is researched manually.	1
Collaborating agencies using the MITA standard interfaces can exchange data on members (Levels 3 and 4 only).	N/A
Access is via Web portal and EDI channels (Level 2 only).	N/A
Effort to Perform	1
There may be inconsistencies in responses.	1
Staff research and respond to request manually.	1
Fewer staff required to support.	2
One stop shop for agencies who share members (Level 3 only).	N/A
Cost Effectiveness	1
Requires research staff.	1
Number of disenrollment requests per day increases significantly (Level 2 only).	N/A
Accuracy of Process	1
Responses are manually validated.	1
Process complies with agency requirements.	1
Utility or Value to Stakeholders	1
Requesters receive the information they need.	1

6.6 Inquire RI Medicaid Member Eligibility

6.6.1 MITA Business Process

Tier 3: Inquire Member Eligibility	
Item	Details
Description	<p>The Inquire Member Eligibility business process 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 will, at minimum, indicate whether the member is eligible for some health benefit plan coverage under Medicaid, in accordance with HIPAA. This transaction may include more detailed information about the Medicaid programs, specific benefits and services, and the provider(s) from which the member may received covered services.</p> <p>NOTE: This process does not include Member requests for eligibility verification. Member initiated requests are handled by the Manage Applicant and Member Communication process.</p>

6.6.2 RI Business Process Overview

The Inquire RI Medicaid Member Eligibility process is overseen by DHS. The majority of inquiry activity is from Medicaid providers.

6.6.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Determine request status as initial or duplicate using rules to determine if the requester is “fishing” (this step is not done).

6.6.4 Systems and Datasets

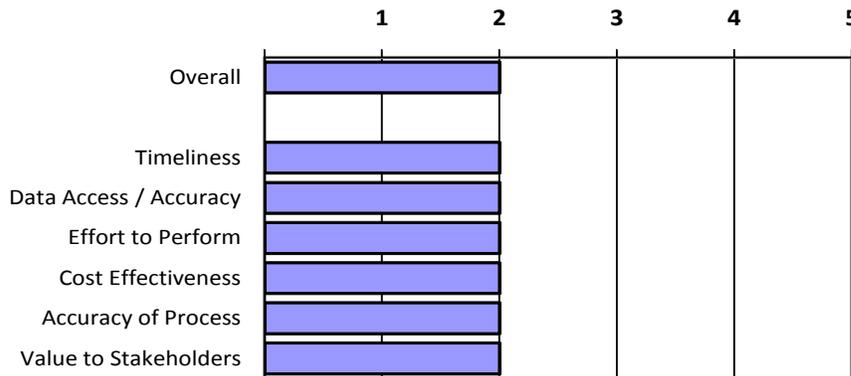
The major systems and datasets that store, transact or exchange data in support of the Inquire RI Medicaid Member Eligibility process include:

- RI-MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state’s eligibility system used for determination and enrollment information.
- REVS - The Recipient Eligibility Verification System (REVS) is a telephone-inquiry system that enables health care providers to quickly and efficiently verify a Medicaid recipient’s current eligibility status.

6.6.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Inquire RI Medicaid Member Eligibility process are rated at a Level 2.

Figure 18 Current Maturity Levels by Dimension: Inquire RI Medicaid Member Eligibility



Examples supporting these Inquire RI Medicaid Member Eligibility process ratings include the following:

- Responses can be immediate
- POS electronic verification is available for providers/services.

- Information can be shared among authorized entities within the state

Table 17 Assessed Maturity Level by MITA Quality: Inquire RI Medicaid Member Eligibility

MITA BCM Qualities & Characteristics	Level
OVERALL	2
Timeliness	2
Member eligibility/enrollment verification is automated via AVRS, point of service devices, Web portal, EDI, but remains siloed.	2
Responses can be immediate.	3
Information can be shared among entities authorized by the Agency.	3
Data Access & Accuracy	2
Automation improves access and accuracy.	2
Access is via AVRS, point of service devices, Web portal and EDI channels.	2
There may be inconsistencies in responses. Media, data format and content differ by program. (Level 1 only)	N/A
Increased use of HIPAA eligibility/enrollment data....Eligibility Reverification Requests and Responses are communicated using HIPAA X12 270/271 and NCPDP Telecommunications Guide v5.1 and Batch Guide v 1.0	2
Requests are expanded to include inquiries re clinical information. For example, a provider can query a Member Registry about the location of needed clinical records anywhere in the state. (Level 4 only)	N/A
Effort to Perform	2
Responses to requests to verify member information are automated.	2
High rate of erroneous eligibility information. (Level 1 only)	N/A
Electronic verification is easier and faster, so providers use it more often.	2
Fewer staff required to support.	2
One stop shop for programs that share members...	3
Cost Effectiveness	2
Automation leads to fewer staff than Level 1...	2
Mailing ID cards to members monthly is costly. (Level 1 only)	N/A
Electronic verification lowers cost to providers and reduces denied claims for ineligible members and non-covered services.	2

MITA BCM Qualities & Characteristics	Level
Accuracy of Process	2
Automation improves accuracy of responses.	2
Process complies with agency requirements. (Level 1 only)	N/A
Utility or Value to Stakeholders	2
Providers have no delay in obtaining responses.	2

6.7 Manage RI Medicaid Member Information

6.7.1 MITA Business Process

Tier 3: Manage Member Information	
Item	Details
Description	<p>The Manage Member Information business process is responsible for managing all operational aspects of the Member Registry, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid.</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.</p> <p>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.</p> <p>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 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.</p> <p>Among the business processes that will interface with the Member Registry are:</p> <ul style="list-style-type: none"> ■ 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. ■ 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 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

Tier 3: Manage Member Information	
Item	Details
	<p>requiring these communication processes to prepare notifications</p> <ul style="list-style-type: none"> ■ The Perform Applicant and Member Outreach, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring provision of outreach and education to the affected applicant or member ■ 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 ■ All Operations Management business processes, e.g., ■ Manage Member Payment, Edit Claim/Encounter, and Authorize Service ■ The Maintain Benefit/Reference Information process, which is the Member Registry's source of benefit package information ■ The Manage Program Information business process, which consolidates key enterprise data for use in reporting, analysis and decision support ■ Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Member Registry for member information ■ Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Member Registry

6.7.2 RI Business Process Overview

The Manage RI Medicaid Member Information process is overseen by DHS. The majority of updates to member information is handled by the DHS field offices. The field office determines if supporting documentation is required or if the applicant is required to go through eligibility determination again (i.e. change in family size).

6.7.3 Business Process Variations

The Manage RI Medicaid Member Information business process does not significantly diverge from the MITA business process definition.

6.7.4 Systems and Datasets

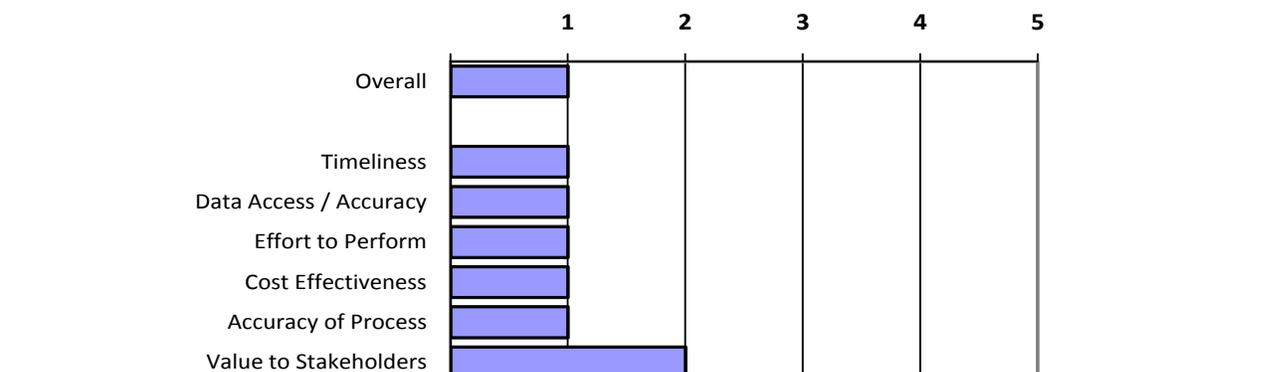
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid Member Information process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state’s eligibility system used for determination and enrollment information.
- Katie Beckett Access Database – Access database used for Katie Beckett program
- SSI Access Database – Access database used to manage the SSI member population

6.7.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Member Information process are rated at a Level 1 with the exception of Utility and Value to Stakeholder which is rated at a Level 2.

Figure 19 Current Maturity Levels by Dimension: Manage RI Medicaid Member Information



Examples supporting these Manage RI Medicaid Member Information process ratings include the following:

- Member updates and data extractions are timely
- Manual efforts are required to update member data/files
- Reconciliation of member data files is manual validated
- Requires numerous staff to update and validate information

Table 18 Assessed Maturity Level by MITA Quality: Manage RI Medicaid Member Information

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Timelier member updates and data extractions.	2
Data exchange partners receive update notifications instantly. (Level 3 only)	N/A
Inadequate audit trails.	1
Data Access & Accuracy	1
Updates are made to individual files manually.	1
Data issues: duplicate identifiers, discrepancies between data stores, and information quality and completeness.	1
Data is shared in batch on a scheduled or ad hoc basis.	1
Effort to Perform	1
Staff must key new information; make updates manually; reconcile and validate data manually.	1
MCO premiums are paid on a daily rate, lowering capitation premium costs for ineligible members	2
Ability to access clinical data electronically to calculate performance and outcome measures. (Level 4 only)	N/A
Cost Effectiveness	1

MITA BCM Qualities & Characteristics	Level
Requires numerous data entry staff to key new and updated information, and reconcile duplicates and data inconsistencies. IT staff needed to load member information generated from other systems.	1
Regional, federated member registries eliminate redundant overhead. (Level 4 only)	N/A
Accuracy of Process	1
Updates and reconciliations must be manually validated.	1
Process focus is on compliance with agency requirements and less on ensuring timely availability of quality/complete data for users.	1
Utility or Value to Stakeholders	2
Automated maintenance of member information ensures that timely, accurate data are available to support all processes needing member information, e.g., MCO enrollment rosters, COB adjudication, etc.	2

6.8 Manage BCCTP Member Information

6.8.1 MITA Business Process

Tier 3: Manage Member Information	
Item	Details
Description	<p>The Manage Member Information business process is responsible for managing all operational aspects of the Member Registry, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid.</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.</p> <p>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.</p> <p>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 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.</p> <p>Among the business processes that will interface with the Member Registry are:</p> <ul style="list-style-type: none"> ■ 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. ■ 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 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

Tier 3: Manage Member Information	
Item	Details
	<p>requiring these communication processes to prepare notifications</p> <ul style="list-style-type: none"> ■ The Perform Applicant and Member Outreach, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring provision of outreach and education to the affected applicant or member ■ 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 ■ All Operations Management business processes, e.g., <ul style="list-style-type: none"> — Manage Member Payment, Edit Claim/Encounter, and Authorize Service — The Maintain Benefit/Reference Information process, which is the Member Registry’s source of benefit package information — The Manage Program Information business process, which consolidates key enterprise data for use in reporting, analysis and decision support — Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Member Registry for member information — Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Member Registry

6.8.2 RI Business Process Overview

The Manage BCCTP Member Information process is overseen by DHS. All updates to InRhodes for the BCCTP population are done manually and tracked in a separate MS Word document.

6.8.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Start: Receive data from Member Management Area and relevant Operations Management business processes (DHS manually maintains eligibility information in a separate MS Word document for tracking changes)

6.8.4 Systems and Datasets

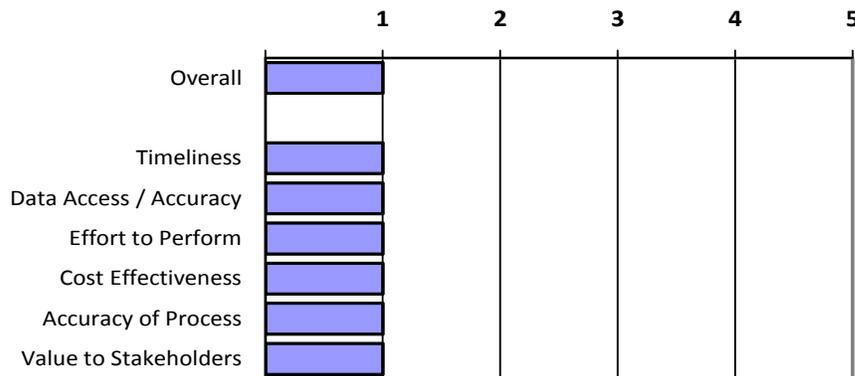
The major systems and datasets that store, transact or exchange data in support of the Manage BCCTP Member Information process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state’s eligibility system used for determination and enrollment information.

6.8.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage BCCTP Member Information process are rated at a Level 1.

Figure 20 Current Maturity Levels by Dimension: Manage BCCTP Member Information



Examples supporting these Manage BCCTP Member Information process ratings include the following:

- Manual efforts are required to update member data/files

- Reconciliation of member data files is manual validated
- Requires numerous staff to update and validate information

Table 19 Assessed Maturity Level by MITA Quality: Manage BCCTP Member Information

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Manual and semi-automated steps delay updates, maintenance processes and require system down-time	1
Data exchange partners receive update notifications instantly. (Level 3 only)	N/A
Inadequate audit trails.	1
Data Access & Accuracy	1
Updates are made to individual files manually.	1
Data issues: duplicate identifiers, discrepancies between data stores, and information quality and completeness.	1
Data is shared in batch on a scheduled or ad hoc basis.	1
Effort to Perform	1
Staff must key new information; make updates manually; reconcile and validate data manually.	1
MCO premiums are paid on a daily rate, lowering capitation premium costs for ineligible members	2
Ability to access clinical data electronically to calculate performance and outcome measures. (Level 4 only)	N/A
Cost Effectiveness	1
Requires numerous data entry staff to key new and updated information, and reconcile duplicates and data inconsistencies. IT staff needed to load member information generated from other systems.	1
Regional, federated member registries eliminate redundant overhead. (Level 4 only)	N/A
Accuracy of Process	1
Updates and reconciliations must be manually validated.	1
Process focus is on compliance with agency requirements and less on ensuring timely availability of quality/complete data for users.	1
Utility or Value to Stakeholders	1

MITA BCM Qualities & Characteristics	Level
Member information is maintained and available, primarily on a schedule or request basis to other business process and users	1

6.9 Manage RI Medicaid Applicant and Member Communication

6.9.1 MITA Business Process

Tier 3: Manage Applicant and Member Communication	
Item	Details
Description	<p>The Manage Applicant and Member Communication business process receives requests for information, appointments and assistance from prospective and current members' communications such as inquiries related to 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>NOTE: 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>

6.9.2 RI Business Process Overview

The Manage RI Medicaid Applicant and Member Communication process is overseen by DHS. The majority of communication to applicant and members is handled by the DHS field offices. The department does handle additional communication needs and generates letters out of the InRhodes system.

6.9.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Log and track communications request and response processing data (communication is not logged and tracked).

6.9.4 Systems and Datasets

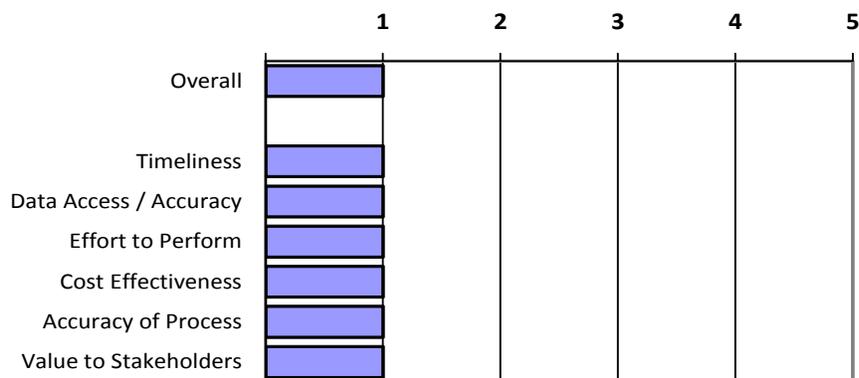
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid Applicant and Member Communication process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state’s eligibility system used for determination and enrollment information.

6.9.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Applicant and Member Communication process are rated at a Level 1.

Figure 21 Current Maturity Levels by Dimension: Manage RI Medicaid Applicant and Member Communication



Examples supporting these Manage RI Medicaid Applicant and Member Communication process ratings include the following:

- Staff research and respond to requests for information manually

- There are many ways (various 800 numbers and email via the internet) a beneficiary contacts DHS for information regarding general questions or their benefits
- There is no specific logging of communications with beneficiaries

Table 20 Assessed Maturity Level by MITA Quality: Manage RI Medicaid Applicant and Member Communication

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Manual and semi-automated steps may require some days to complete response.	1
Research and response for these standardized communications are immediate or within batch response parameters. (Level 2 Only)	N/A
Data Access & Accuracy	1
Responses are made manually and there may be inconsistency and inaccuracy (within agency tolerance level).	1
Access is via Web portal and EDI channels. (Level 2 Only)	N/A
Member information belonging to different entities can be virtually consolidated to form a single view. (Level 3 Only)	N/A
Agencies support deployment of internet access points, such as kiosks and low cost telecommunication devices such as cell phones for distribution to mobile communities, to alleviate communications barriers. (Level 3 Only)	N/A
Member communication is organized around the “no wrong door” concept, which ensures that regardless of point of entry, current and prospective members will be able to access information about all programs. (Level 3 Only)	N/A
Effort to Perform	1
Staff research and respond to requests manually. Requests are received from members in non-standard formats.	1
Member communications are primarily conducted via paper and phone. However, states begin using Websites to provide member information on providers and health plans, and responses to inquires that can be responded to online or by phone.	2
Access to clinical information improves efficiency. (Level 4 Only)	N/A
Collaboration among agencies achieves a one-stop shop for member inquiries, e.g., mental health member requests claim payment status from Medicaid, Mental Health Department, Community Health Center. (Level 3 Only)	N/A

MITA BCM Qualities & Characteristics	Level
Information entered into provider electronic health records can also trigger specific messages to members regarding special programs and disease management information. (Level 4 only)	N/A
Cost Effectiveness	1
Requires research staff.	1
Number of responses per day increases significantly. (Level 2 Only)	N/A
Accuracy of Process	1
Responses are manually validated, e.g., call center audits; member satisfaction survey. Process complies with agency requirements.	1
Member Registries use standardized contact data, including NPS address standards, to alleviate postal delivery failures. (Level 3 Only)	N/A
Utility or Value to Stakeholders	1
Members receive the information they need.	1
Member communications are linguistically, culturally, and competency appropriate, but require considerable manual intervention for paper communications.	2
Public health alerts can be triggered by clinical information in the patient's electronic health record. (Level 4 Only)	1

6.10 Manage RI Medicaid Member Grievance and Appeal

6.10.1 MITA Business Process

Tier 3: Manage Member Grievance and Appeal	
Item	Details
Description	<p>The Manage Member Grievance and Appeal business process 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 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. 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.</p> <p>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>NOTE: States may define “grievance” and “appeal” differently, perhaps because of state laws. States must enforce the Balance Budget Act requirements for grievance and appeals processes in their MCO contracts at 42 CFR Part 438.400. They may adopt these for non-MCO programs.</p>

6.10.2 RI Business Process Overview

The Manage RI Medicaid Member Grievance and Appeal process is overseen by DHS Hearing Office within the Legal Division. Applicants/Members are required to complete a standard form to file a grievance/appeal to be reviewed by DHS.

6.10.3 Business Process Variations

The Manage RI Medicaid Member Grievance and Appeal business process does not significantly diverge from the MITA business process definition.

6.10.4 Systems and Datasets

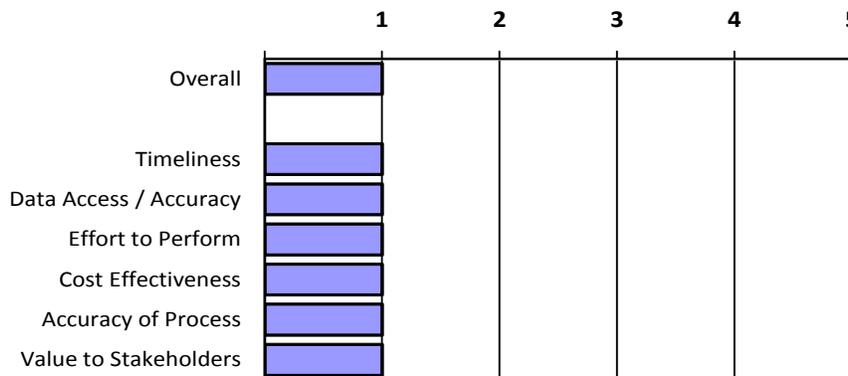
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid Member Grievance and Appeal process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state’s eligibility system used for determination and enrollment information.

6.10.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Member Grievance and Appeal process are rated at a Level 1.

Figure 22 Current Maturity Levels by Dimension: Manage RI Medicaid Member Grievance and Appeal



Examples supporting these Manage RI Medicaid Member Grievance and Appeal process ratings include the following:

- Most aspects of the process are manual
- Grievance and Appeal process is automatically included in member communication materials
- Online access to file grievance or appeal is not available

Table 21 Assessed Maturity Level by MITA Quality: Manage RI Medicaid Member Grievance and Appeal

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
This is an all-manual process.	1
Confidential documents are transferred by certified mail (Does not apply to this business process).	N/A
Responses to research questions within the agency are immediate (Level 2 only).	N/A
Cases typically require months to complete.	1
Data Access & Accuracy	1
Information is researched manually.	1
Access is via Web portal and EDI channels (Level 2 only).	N/A
There is more consistency in the steps taken in the review and resolution process.	2
Agency standards for inquiries are introduced.	2
Effort to Perform	1
Staff research and maintain manually.	1
MITA standard interfaces are also used for inquiry and response for acquisition of information needed to build the case. (Level 3 only)	N/A
The original case against a provider may be triggered directly from the clinical record. (Level 4 only)	N/A
Medicaid collaborates with other health and human services agencies that manage appeals to create a one-stop shop model for both provider and consumer appeals. (Level 3 only)	N/A

MITA BCM Qualities & Characteristics	Level
Cost Effectiveness	1
Process is labor-intensive. Results take several months.	1
Collaboration with sister agencies that conduct appeals cases increases costs-effectiveness.	3
Standardization of input and case results allows staff to focus on analytical activities. (Level 3 only)	N/A
Accuracy of Process	1
Terms of the settlement or results of the hearing are manually documented according to the administrative rules of the state.	1
There may be inconsistencies between similar cases. Process complies with agency requirements.	1
Utility or Value to Stakeholders	1
Business process complies with agency and state requirements for a fair hearing and disposition.	1

6.11 Perform RI Medicaid Population and Member Outreach

6.11.1 MITA Business Process

Tier 3: Perform Population and Member Outreach	
Item	Details
Description	<p>The Perform Population and Member Outreach business process originates internally within the Agency for purposes such as:</p> <ul style="list-style-type: none"> ■ Notifying 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). <p>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>NOTE: 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 handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bidirectional communication.</p>

6.11.2 RI Business Process Overview

The Perform RI Medicaid Population and Member Outreach process is overseen by DHS. The department uses TV, ads, fact sheets, site visits, advocacy groups and their web site to perform outreach functions.

All applicant outreach for the Breast and Cervical Cancer Treatment Program (BCCTP) is handled by the Department of Health's (DOH) Women's Cancer Screening Program.

6.11.3 Business Process Variations

The Perform RI Medicaid Population and Member Outreach business process does not significantly diverge from the MITA business process definition.

6.11.4 Systems and Datasets

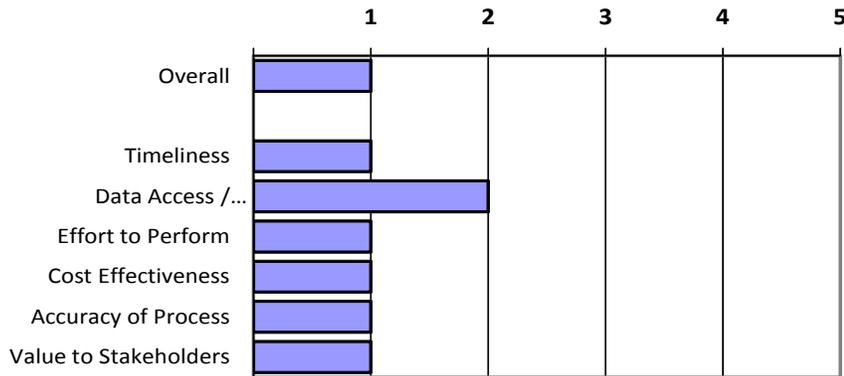
The major systems and datasets that store, transact or exchange data in support of the Perform RI Medicaid Population and Member Outreach process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – the state's eligibility system used for determination and enrollment information.

6.11.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Perform RI Medicaid Population and Member Outreach process are rated at a Level 1 with Data Access and Accuracy at a Level 2.

Figure 23 Current Maturity Levels by Dimension: Perform RI Medicaid Population and Member Outreach



Examples supporting these Perform RI Medicaid Population and Member Outreach process ratings include the following:

- Staff research and respond to requests for outreach information manually
- Outreach materials are available via DHS web site
- Non-routine outreach is time consuming

Table 22 Assessed Maturity Level by MITA Quality: Perform RI Medicaid Population and Member Outreach

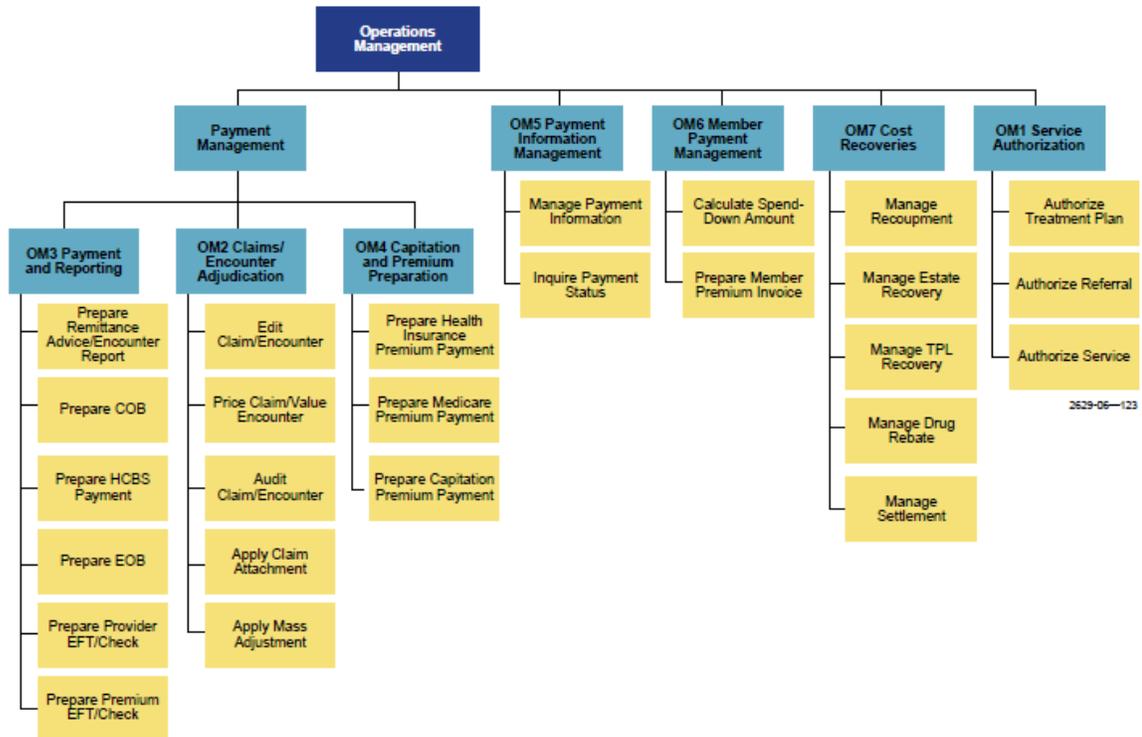
MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
This is primarily an all-manual process. "It takes the time it takes".	1
Triggers create messages from members' EHRs/PHRs that map to automated response messages such as eligibility/enrollment application contained in an Outreach and Education database. (Level 4 only)	N/A
Members must wait in phone queue to make inquiries and may have to contact multiple programs to access the needed information.	1

MITA BCM Qualities & Characteristics	Level
Paper and non-routine outreach is still time-consuming. Access to electronic sources of outreach and education materials somewhat reduces time that current and prospective members must spend discovering needed information.	2
Data Access & Accuracy	2
Automation improves access and accuracy. Increased standardization of administrative data, and improved data manipulation for decision support improves accuracy of population targeting.	2
Current and prospective members can access needed information via Web portal.	2
Increasing use of functionally, linguistically, culturally, and competency appropriate outreach and education materials improve members' access to information.	2
Use of NPS standards for member data improves accuracy for mailing purposes.	3
Effort to Perform	1
Materials can be posted on a Web site for downloading by members.	2
Developing functionally, linguistically, culturally, and competency appropriate outreach and education materials is difficult.	1
As a result, more staff is required to assist members needing such material.	1
Effort is required to research target current and prospective target populations and track mailings.	1
Mailings are more successful because member records have NPS standard data and member registries' use algorithmic identification to improve data accuracy, reducing the need to follow up with members by other means or missing outreach and education opportunities.	3
Cost Effectiveness	1
Automation reduces level of staffing required to target populations needing outreach and education.	2
Paper materials are expensive to produce. Incurs postal expenses and cost of undelivered mail.	1
NPS standard member contact information decreases undelivered mailings.	3
Staff still needed where the materials are not appropriate for member.	1
Accuracy of Process	1
Difficult to determine impact of outreach and education.	1
Agency can target members who are not accessing information. (Level 2 only)	N/A
Current and prospective members continue to need assistance by phone.	1
Utility or Value to Stakeholders	1

MITA BCM Qualities & Characteristics	Level
Business process complies with agency and state requirements for educating the members regarding rules and regulations and how to communicate with the Agency.	1
Outreach material is functionally, linguistically, culturally, and competency appropriate, but at great expense.	2

OPERATIONS MANAGEMENT

There are twenty six business processes defined within the MITA framework for Operations Management.



The RI Medicaid program performs twenty of the defined business processes:

- Apply Claim Attachment
- Apply Mass Adjustment
- Authorize Service
- Authorize Treatment Plan
- Calculate Spend-Down Amount
- Edit and Audit Claim-Encounter Process

- Inquire Payment Status
- Manage Drug Rebate
- Manage Estate Recovery
- Manage Recoupment
- Manage Settlement
- Manage TPL Recovery
- Prepare Capitation Premium Payment
- Prepare EOB
- Prepare Health Insurance Premium Payment
- Prepare Medicare Premium Payment
- Prepare Member Premium Invoice
- Prepare Provider EFT-check
- Prepare Remittance Advice-Encounter Report
- Price Claim - Value Encounter

The following MITA Business Processes are not performed by RI:

- Authorize Referral – Not applicable to RI Medicaid
- Manage Payment Information - Not applicable to RI Medicaid
- Prepare COB - Not applicable to RI Medicaid
- Prepare HCBS Payment – Covered in Prepare RI Medicaid Provider and Premium EFT

Due to the large number of business processes within the Operations Management business area, four subgroups have been created for organization purposes:

- Authorizations
- TPL

- Claims Processing
- Premium Payments

7 OPERATIONS MANAGEMENT: AUTHORIZE SERVICES

7.1 Authorize Personal Choice Waiver Service

7.1.1 MITA Business Process

Tier 3: Authorize Service	
Item	Details
Description	<p>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.</p> <p>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.</p> <p>After review, a referral is approved, modified, 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>

7.1.2 RI Business Process Overview

Under the Personal Choice Waiver, overseen by the DHS Office of Institutional and Community Services and Support, if a client needs an item that is not covered by Medicaid, such as a washing machine, and wants to use money within the predetermined budget (refer to Authorize Care Plan process) then the client submits a request to the Office of Institutional and Community Services and Support with supporting documentation for justification. The client's request is reviewed and either approved or denied. If approved, the Fiscal Agent, either PARI or Options, is notified of the authorization to purchase items.

7.1.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Assign a tracking number. (Tracking number is assigned when the care plan is established.)
- Validate diagnosis code (These authorizations are for non-medical/non-Medicaid covered items)
- Validate procedure code ((These authorizations are for non-medical/non-Medicaid covered items).
- Deny based on insufficient/erroneous data or authorization for service not medically necessary and send via Manage Provider Communication (communication is made via Manage Applicant and Member Communication)
- Load review results into Benefits/Reference repository for access during adjudication process. (Not done for this process)

7.1.4 Systems and Datasets

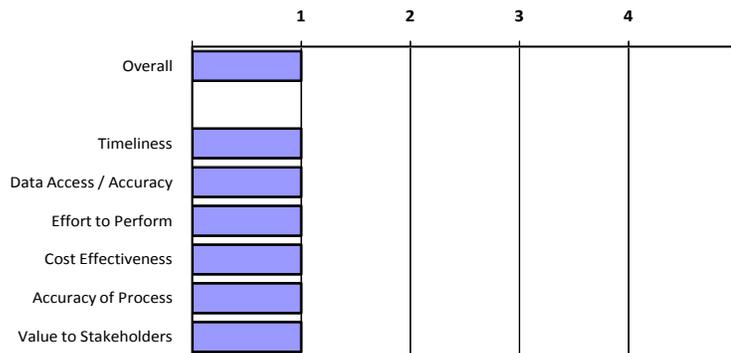
The major systems and datasets that store, transact or exchange data in support of the authorize service include:

- Consumer Direction Module (CDM) – used for the Personal Choice Waiver by the participant, support broker, financial management services agency and state administrator for ongoing, timely, and efficient monitoring.
- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – RI Eligibility system used for determination and enrollment information.

7.1.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Authorize Service process are rated at a Level 1.

Figure 24 Current Maturity Levels by Dimension: Authorize Personal Choice Waiver Service



Examples supporting these Authorize Personal Choice Waiver Service process ratings include the following:

- Authorization requests are primarily paper
- Format and content are not HIPAA compliant
- Information is manually validated

Table 23 Assessed Maturity Level by MITA Quality: Authorize Personal Choice Waiver Service

MITA BCM Qualities & Characteristics	Level
OVERALL	1
Timeliness	1
Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines. Decisions may take several days	1
Data Access & Accuracy	1
Authorize Service request is primarily paper, phone or fax based.	1
Format and content are not HIPAA compliant.	1
Inflexibility in Authorize Service processing is a key factor in the proliferation of siloed systems outside of the MMIS, especially for waiver programs that determine medical appropriateness and service authorization differently than traditional Medicaid programs. As a result, data is not comparable across silos	1
Preconditions for achieving this level are use of established RHIOs and semantic interoperability. (Level 4 only)	N/A
Effort to Perform	1
Information is manually validated and manually transferred from submitted paper to the MMIS.	1
If an Authorize Service request requires additional information, the reviewer must manually contact the submitter/provider, which delays processing and is resource intensive.	1
Related processes are de-coupled, allowing changes to be made in the Authorize Service process with reduced potential for unintended downstream processing consequences. (Level 3 only)	N/A
Cost Effectiveness	1
Since these systems duplicate MMIS capabilities and do not meet current MMIS requirements, states lose development, design, and implementation as well as operational federal funding participation (FFP).	1

MITA BCM Qualities & Characteristics	Level
Accuracy of Process	1
Authorize Service requests are primarily manually validated against state-specific business rules. As a result, states may conduct Authorize Service retrospectively as an audit, missing opportunities to ensure appropriate use of services.	1
Related processes are tightly integrated, making it difficult to ensure that changes to service authorization process do not result in unintended cross-process consequences	1
Utility or Value to Stakeholders	1
Business process complies with agency and state requirements	1