

## 10.2 Manage RI Medicaid Case

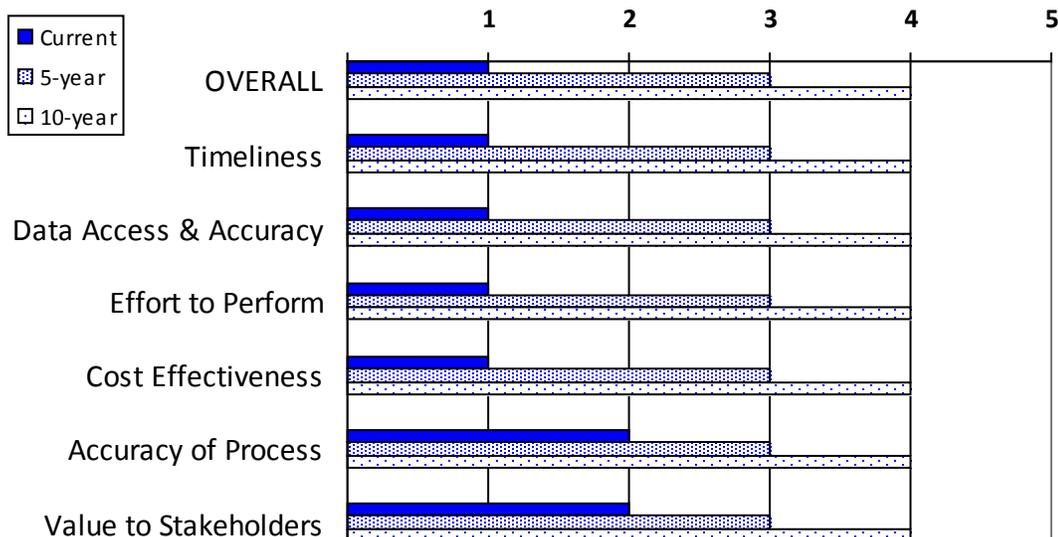
### 10.2.1 MITA Business Process Model

- Program Integrity Management: PI Manage Case

### 10.2.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid Case business process will be at a capability level 3 in 5 years, with improved automation and standardization in case tracking. Within 10 years, all aspects of this process will be at a level 4, with immediate case updates and use of clinical data updated in real-time through the Department’s increasingly federated systems architecture. Most qualities for this business process currently are at a level 1.

**Figure 43: Current and Future Maturity Levels by Quality: Manage RI Medicaid Case**



### **10.2.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Manage RI Medicaid Case business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization.<sup>155</sup>
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims.<sup>156</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create mechanisms that support the Department's goal of rewarding improved plan performance.<sup>157</sup>
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser. More enrollees in Managed Care will increase the volume of encounters and facilitate the need for cleaner, more accurate data.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global

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<sup>155</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>156</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>157</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>158</sup>

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase volume of Medicaid recipients to be managed.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity.<sup>159</sup>
- Under the Global Waiver, the goal to stimulate innovation and adoption of best practices.<sup>160</sup>
- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.

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<sup>158</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>159</sup> Gary Alexander/Elena Niclolla, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>160</sup> *ibid*

## 10.2.4 Expected Characteristics

### 5-Year View

With increased standardization and almost complete automation, the Manage RI Medicaid Case business process will be at a capability level 3 within 5 years.

Anti-fraud algorithms will be applied more consistently in the claims processing system to assist with case-building. Results of these and other case-building methods will rely increasingly on standardized electronic data exchanges within the Agency and its partners, including federated case registries.

As the various internal case tracking systems converge, Program Integrity Section's customers will receive more timely and reliable information about case actions. Performance metrics will be readily available in the Section's case tracking system, including investigative hours and costs expended per case. In addition to increasing electronic data entry and interchange within the Program Integrity case tracking tools, paper documents will be scanned and linked electronically to further automate the audit file. Due to these increased efficiencies, staff can be redirected to more labor intensive tasks, e.g., site visits and care management.

The table below summarizes the capability improvements for the Manage RI Medicaid Case business process that are targeted over the next 5 years.

### 10-Year View

Immediate processing using real-time clinical data and the Department's increasingly federated systems architecture will support a level 4 capability for this business process within 10 years.

Providers, members, and care managers will access standardized Member Registries and electronic health records to validate and view real-time clinical data. Member verification will include biometric authentication (e.g., a thumbprint scan).

Program Integrity Section's anti-fraud partners will overcome their data exchange obstacles and improve their sharing of case information. Real-time updates to federated case registries will be triggered automatically. There will be increased

collaboration within the Department and among other agencies in case tracking, case management and investigative work.

Due to increased automation and greater use of clinical data, staff can be refocused increasingly on performance outcomes, care management, and quality assurance. Additional specialized medical positions (e.g., dentists) may be established in Program Integrity Section to take advantage of the increased availability of clinical data.

The table below summarizes the capability improvements for the Manage RI Medicaid Case business process that are targeted 5-10 years from now.

**Table 43: Future Maturity Level by MITA Quality: Manage RI Medicaid Case**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Process will be standardized almost completely automated.	3	Process will be immediate using real-time clinical data and will interface with other processes via federated architectures.	4
<b>Timeliness</b>	Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	3	Process time will be immediate. Clinical data will be available in real time.	4
<b>Data Access &amp; Accuracy</b>	Process will have almost eliminated its use of non-electronic interchange and has automated most processes.	3	Process will interface with other processes via federated architectures, including direct access to clinical data.	4
<b>Effort to Perform</b>	Updates will be distributed to data sharing partners. Distributed update notifications to federated registries.	3	Data will trigger registry updates and pushes data to other applications (e.g., EHRs, registries).	4

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Cost Effectiveness</b>	Due to increased efficiency, staff can be redirected to more productive tasks.	3	Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care/disease management; stakeholder satisfaction.	4
<b>Accuracy of Process</b>	Rules will be consistently applied. Decisions will be uniform.	3	Use of clinical data will improve consistency of results.	4
<b>Value to Stakeholders</b>	Stakeholders will experience seamless and efficient program communications no matter how or where they contact the Agency.	3	Providers, members, and care managers will access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	4

# 11.0 PROGRAM MANAGEMENT

## 11.1 Designate Approved Drug Formulary

### 11.1.1 MITA Business Process Model

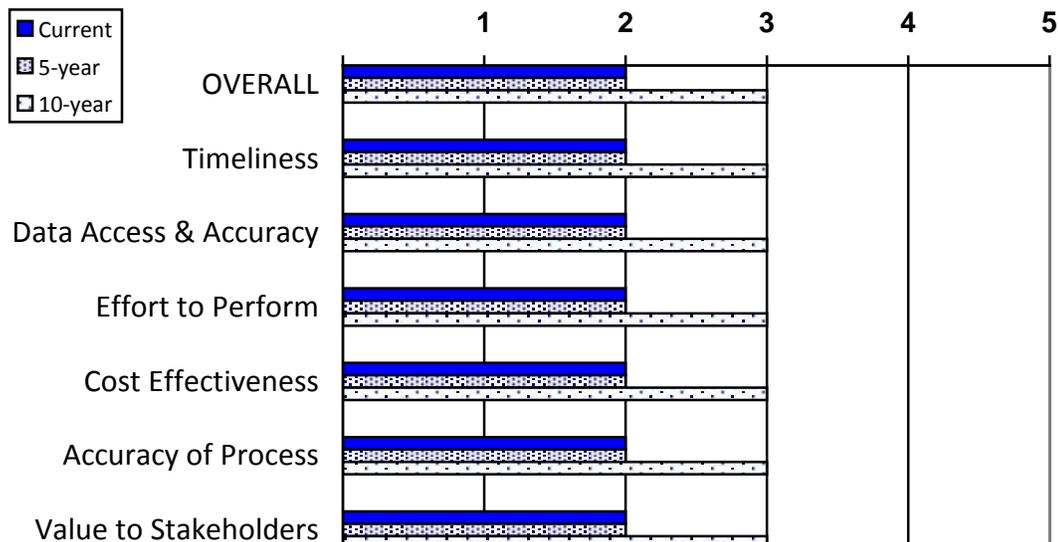
- Program Management: PG1 Designate Approved Service/Drug Formulary

### 11.1.2 Future Capability Overview

As shown in the figure below, all aspects of the Designate Approved Drug Formulary business process will remain unchanged in 5 years, with no major initiatives currently underway that are expected to significantly impact the maturity of this process.

Within 10 years, all aspects of this process will be at a level 3, where data analysis is automated and specialized applications are used to study patterns and “what if” analysis. All qualities for this business process currently are at a level 2.

**Figure 44: Current and Future Maturity Levels by Quality: Designate Approved Drug Formulary**



### **11.1.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Designate Approved Drug Formulary business process:

#### **Strategic Planning Influences**

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.<sup>161</sup>
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This includes maximizing available service options.<sup>162</sup>

#### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

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<sup>161</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>162</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

### 11.1.4 Expected Characteristics

#### 5-Year View

The Designate Approved Drug Formulary business process will remain at a capability level 2 within 5 years.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for all qualities of the Designate Approved Drug Formulary are at Level 2. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.**

The table below summarizes the capability levels for the Designate Approved Drug Formulary business process that are targeted over the next 5 years.

#### 10-Year View

Due to the ability of business experts to review and change parameters interactively, changes are quickly accommodated without the need for programming modifications. Standardization of data and information exchange across agencies improves decision making and will support a level 3 capability for this business process within 10 years.

The table below summarizes the capability improvements for the Designate Approved Drug Formulary business process that are targeted 5-10 years from now.

**Table 44: Future Maturity Level by MITA Quality: Designate Approved Drug Formulary**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Data analysis is primarily automated. (No change from current view).	2	Data analysis is automated and specialized applications are used to study patterns and “what if” analysis.	3
<b>Timeliness</b>	By adhering to national standard codes, timeliness improves over Level 1. (No change from current view).	2	Use of MITA approved code standards improves timeliness of agency approvals over Level 2.	3
<b>Data Access &amp; Accuracy</b>	Information is usually accessible and access to national data services is instantaneous. (No change from current view).	2	Access to information is immediate.	3
<b>Effort to Perform</b>	The review and approval process is more efficient than at Level 1 due to the use of automated tools. (No change from current view).	2	Use of MITA standard interface (which includes data standards) improves efficiency over Level 2.	3
<b>Cost Effectiveness</b>	Effectiveness is improved because staff has better analytical tools to use in assessing code sets and formularies. (No change from current view).	2	Effectiveness further improves through use of MITA standard interfaces and full adoption of HIPAA codes which can be compared across States.	3
<b>Accuracy of Process</b>	Automated processes produce increased accuracy from Level 1. (No change from current view).	2	Increased use of national codes and automated reviewing tools increases accuracy from Level 2.	3
<b>Value to Stakeholders</b>	Increased use of national standard codes improves stakeholder satisfaction over Level 1 with timeliness and consistency of decisions. (No change from current view).	2	Use of MITA data standards further increases satisfaction over Level 2.	3

## 11.2 Designate Approved Medicaid Service:

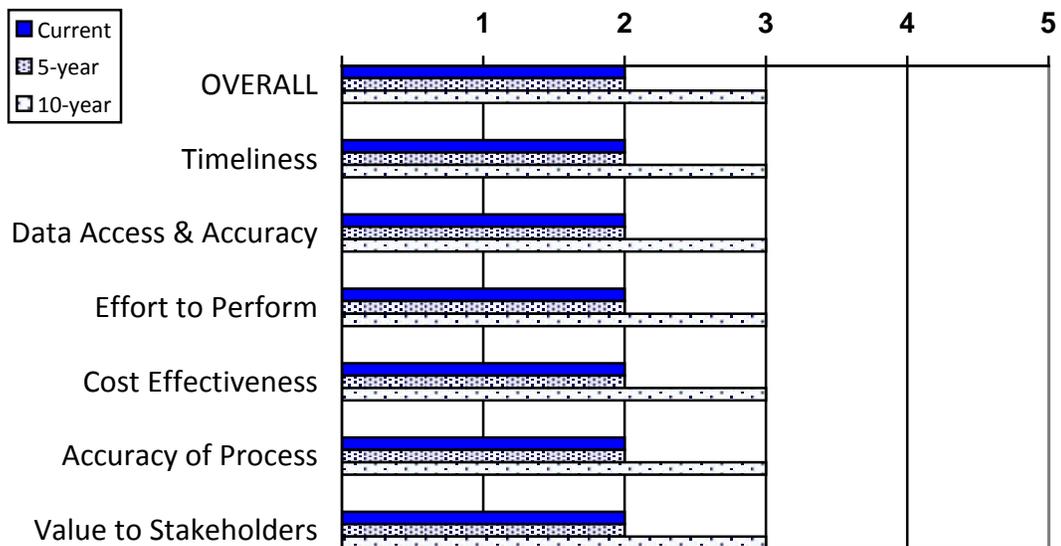
### 11.2.1 MITA Business Process Model

- Program Management: PG1 Designate Approved Service/Drug Formulary

### 11.2.2 Future Capability Overview

As shown in the figure below, all aspects of the Designate Approved Medicaid Service business process will remain unchanged in 5 years, with no major initiatives currently underway that are expected to significantly impact the maturity of this process. Within 10 years, all aspects of this process will be at a level 3, where data analysis is automated and specialized applications are used to study patterns and “what if” analysis. All qualities for this business process currently are at a level 2.

**Figure 45: Current and Future Maturity Levels by Quality: Designate Approved Medicaid Service**



### **11.2.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Designate Approved Medicaid Service business process:

#### **Strategic Planning Influences**

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.<sup>163</sup>
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This includes maximizing available service options.<sup>164</sup>

#### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

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<sup>163</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>164</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

## 11.2.4 Expected Characteristics

### 5-Year View

The Designate Approved Medicaid Service business process will remain at a capability level 2 within 5 years.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for all qualities of the Designate Approved Medicaid Service are at Level 2. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.**

The table below summarizes the capability levels for the Designate Approved Medicaid Service business process that are targeted over the next 5 years.

### 10-Year View

Due to the ability of business experts to review and change parameters interactively, changes are quickly accommodated without the need for programming modifications. Standardization of data and information exchange across agencies improves decision making and will support a level 3 capability for this business process within 10 years.

The table below summarizes the capability improvements for the Designate Approved Medicaid Service business process that are targeted 5-10 years from now.

**Table 45: Future Maturity Level by MITA Quality: Designate Approved Medicaid Service**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Data analysis is primarily automated. (No change from current view).	2	Data analysis is automated and specialized applications are used to study patterns and “what if” analysis.	3
<b>Timeliness</b>	By adhering to national standard codes, timeliness improves over Level 1. (No change from current view).	2	Use of MITA approved code standards improves timeliness of agency approvals over Level 2.	3
<b>Data Access &amp; Accuracy</b>	Information is usually accessible and access to national data services is instantaneous. (No change from current view).	2	Access to information is immediate.	3
<b>Effort to Perform</b>	The review and approval process is more efficient than at Level 1 due to the use of automated tools. (No change from current view).	2	Use of MITA standard interface (which includes data standards) improves efficiency over Level 2.	3
<b>Cost Effectiveness</b>	Effectiveness is improved because staff has better analytical tools to use in assessing code sets and formularies. (No change from current view).	2	Effectiveness further improves through use of MITA standard interfaces and full adoption of HIPAA codes which can be compared across States.	3
<b>Accuracy of Process</b>	Automated processes produce increased accuracy from Level 1. (No change from current view).	2	Increased use of national codes and automated reviewing tools increases accuracy from Level 2.	3
<b>Value to Stakeholders</b>	Increased use of national standard codes improves stakeholder satisfaction over Level 1 with timeliness and consistency of decisions. (No change from current view).	2	Use of MITA data standards further increases satisfaction over Level 2.	3

## 11.3 Develop and Maintain Benefit Package:

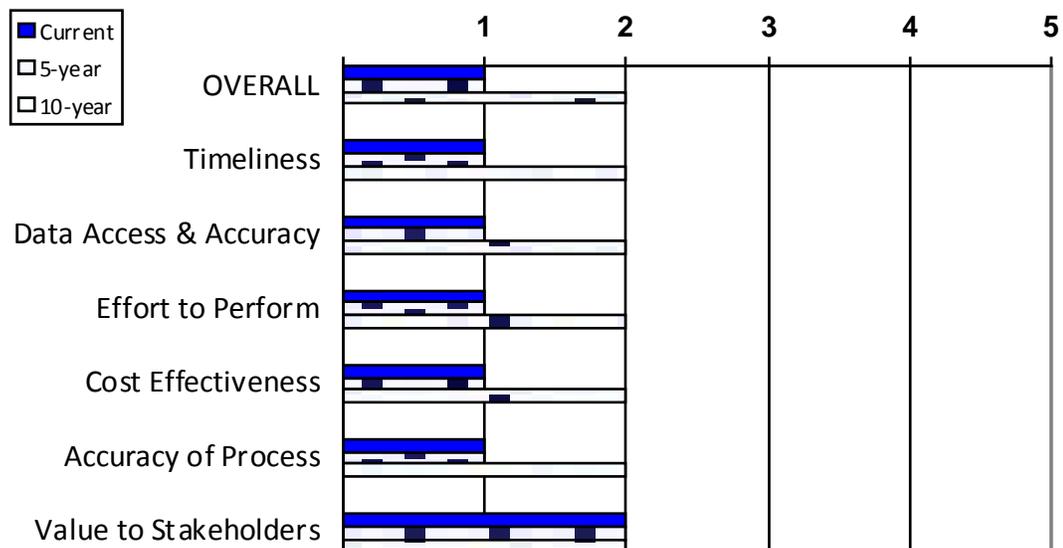
### 11.3.1 MITA Business Process Model

- Program Management: PG1 Develop and Maintain Benefit Package

### 11.3.2 Future Capability Overview

As shown in the figure below, all aspects of the Develop and Maintain Benefit Package business process will remain unchanged in 5 years, with no major initiatives currently underway that are expected to significantly impact the maturity of this process. Within 10 years, all aspects of this process will be at a level 2, where the agency uses tools to extensively analyze data to support maintenance of the benefit packages. Most qualities for this business process currently are at a level 1.

Figure 46: Current and Future Maturity Levels by Quality: Develop and Maintain Benefit Package



### **11.3.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Develop and Maintain Benefit Package business process:

#### **Strategic Planning Influences**

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.<sup>165</sup>
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This includes maximizing available service options.<sup>166</sup>
- Improving health outcomes through more organized care is a goal of the Global Waiver Demonstration. Aspects of this goal include enhanced access to preventive care and improved management of patients with complex medical conditions. This business process is instrumental to the planning efforts associated with these aspects.<sup>167</sup>

#### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-

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<sup>165</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>166</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>167</sup> *ibid*

related components of this system and are critical to the efficient operation of this business process.

- Standardized tracking of prospective policy changes is not currently a priority for the department.

### 11.3.4 Expected Characteristics

#### 5-Year View

The Develop and Maintain Benefit Package business process will remain at a capability level 1 within 5 years.

**This RI Medicaid business process will remain at Level 1 within 5 years. Current capabilities for all qualities of the Develop and Maintain Benefit Package are at Level 1. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.**

The table below summarizes the capability levels for the Develop and Maintain Benefit Package business process that are targeted over the next 5 years.

#### 10-Year View

Immediate processing and automation of benefit package design, including the availability of clinical data, will support a level 3 capability for this business process within 10 years.

With increased automation and the ability for the department to do predictive modeling for policy changes will enable more flexibility in the maintenance of the benefit package. “Consumer driven” health care, with more choices among services and provider types, will be a feature of benefit packages for which the member is eligible.

The table below summarizes the capability improvements for the Develop and Maintain Benefit Package business process that are targeted 5-10 years from now.

**Table 46: Future Maturity Level by MITA Quality: Develop and Maintain Benefit Package**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Benefit package selections have pre-set services and provider types. (No change from the Current View)	1	Waiver programs are structured to permit more flexibility around selection of services and providers within a benefit package.	2
<b>Timeliness</b>	The benefit package changes take a significant amount of time to complete, depending on the complexity and cost of coverage affected. (No change from the Current View)	1	Automation of analysis facilitates prompt maintenance of the benefit package.	2
<b>Data Access &amp; Accuracy</b>	The manual nature of this process introduces the potential for inaccuracies. (No change from the Current View)	1	More automation and standardization reduces inaccuracies.	2
<b>Effort to Perform</b>	Changes to the benefit plan are primarily manual creating inefficiency. (No change from the Current View)	1	Automation improves efficiency.	2
<b>Cost Effectiveness</b>	Benefit package maintenance is duplicated among multiple agencies including the Medicaid agency. Lack of coordination reduces effectiveness. (No change from the Current View)	1	Agencies collaborate on development of benefit packages and use an MOU to designate areas of shared services. This reduces the cost of benefit plan maintenance.	2
<b>Accuracy of Process</b>	Benefit packages are inflexible and lock members into a single package. (No change from the Current View)	1	Benefit packages are somewhat flexible but cannot be shared across programs.	2
<b>Value to Stakeholders</b>	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1. (No change from the Current	2	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	2

## 11.4 Manage Managed Care Rate Setting:

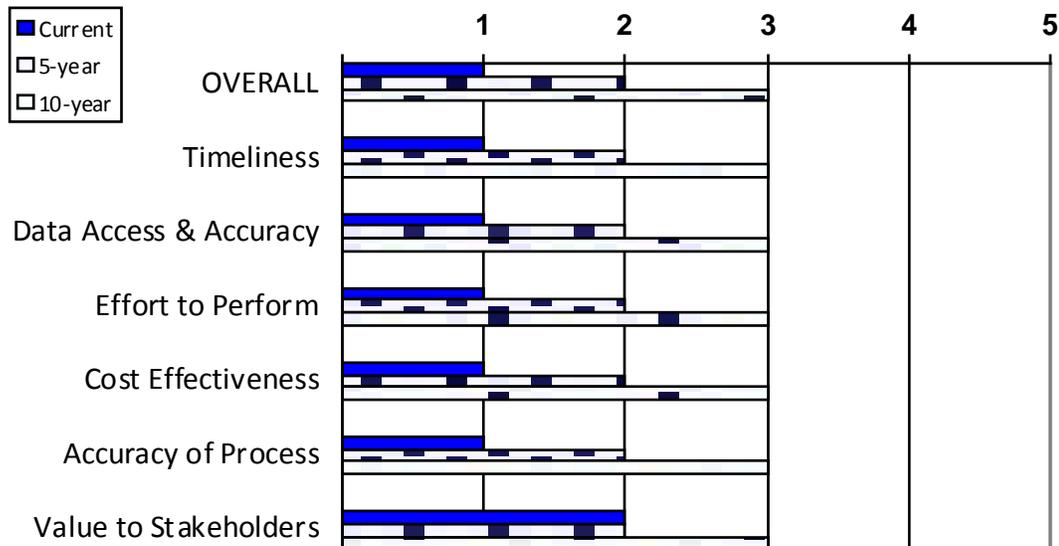
### 11.4.1 MITA Business Process Model

- Program Management: PG1 Manage Rate Setting

### 11.4.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage Managed Care Rate Setting business process will mature to a level 2 in 5 years. Within 10 years, all aspects of this process will be at a level 3, where standard interface ensures the comparability of data used for rate setting across entities accepting the standard. Most qualities for this business process are currently at a level 1.

Figure 47: Current and Future Maturity Levels by Quality: Manage Managed Care Rate Setting



### 11.4.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Manage Managed Care Rate Setting business process:

#### Strategic Planning Influences

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.<sup>168</sup>
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This may include enhancements to managed care plan monitoring and rate-setting methods.<sup>169</sup>
- Improving health outcomes through more organized care is a goal of the Global Waiver Demonstration. An aspect of this goal is expected to include increased enrollment in Medicaid managed care plans.<sup>170</sup>
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>171</sup>

<sup>168</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>169</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>170</sup> *ibid*

<sup>171</sup> *ibid*

## **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

### **11.4.4 Expected Characteristics**

#### **5-Year View**

Most capabilities of the Manage Managed Care Rate Setting business process will mature to a level 2 in 5 years with the process a mix of manual and automated activities. Information is received from multiple sources. The overall level will only reach a capability level of 2 due to the process not being immediate.

The table below summarizes the capability levels for the Manage Managed Care Rate Setting business process that are targeted over the next 5 years.

#### **10-Year View**

At this time the process is primarily automated. Messages are exchanged with trading partners to obtain information. MITA standard interface ensures the comparability of data used for rate setting across entities accepting the standard.

The table below summarizes the capability improvements for the Manage Managed Care Rate Setting business process that are targeted 5-10 years from now.

**Table 47: Future Maturity Level by MITA Quality: Manage Managed Care Rate Setting**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The process is a mix of manual and automated activities. Information is received from multiple sources.	2	The process is primarily automated. Messages are exchanged with trading partners to obtain information.	3
<b>Timeliness</b>	Increased automation shortens the time required to complete rate setting functions, improving timeliness over Level 1.	2	Use of MITA standard interface and data standards further reduces time required for rate setting, improving timeliness over Level 2.	3
<b>Data Access &amp; Accuracy</b>	Accuracy and consistency of data used in the process improves over Level 1 due to increased automation and HIPAA and other data standards.	2	Use of MITA standardized interfaces and data standards ensures accuracy of data. Data accuracy is measured as 99%.	3
<b>Effort to Perform</b>	Use of automation, HIPAA, and other data standards increase efficiency over Level 1.	2	Use of MITA standard data improves comparability of data used in the setting of rates. Automation allows staff to focus on strategic aspects of rate setting and Medicaid enterprise policy regarding rates.	3
<b>Cost Effectiveness</b>	Automation and HIPAA and other data standards increase cost-effectiveness over Level 1.	2	The process demonstrates improvement value projected by the Medicaid enterprise. Use of data standards in researching and analyzing rate data results in development of appropriate rates using appropriate resources.	3
<b>Accuracy of Process</b>	Improvements in the rate setting process, including automation, results in more accurate rates that encourage provider participation while helping to maintain cost controls.	2	Use of MITA standards improves ability to compare information used in rate setting with other data which in turn further improves the appropriateness of State rates.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Value to Stakeholders</b>	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1. (No change from the Current View)	2	Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	3

## 11.5 Manage RI Medicaid Rate Setting:

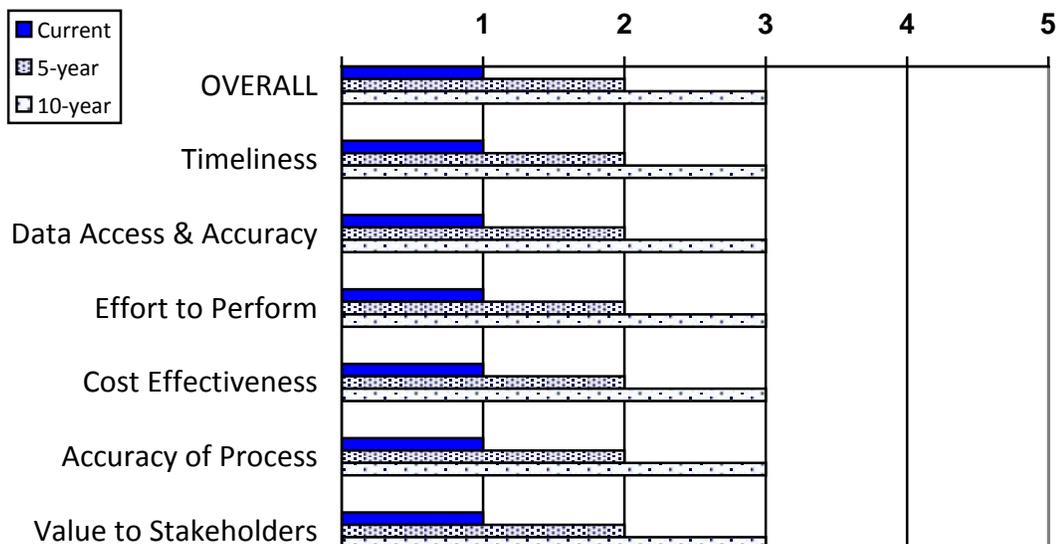
### 11.5.1 MITA Business Process Model

- Program Management: PG1 Manage Rate Setting

### 11.5.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid Rate Setting business process will mature to a level 2 in 5 years, with increased standardization of data and some automation. Within 10 years, all aspects of this process will be at a level 3, with automation of rates and consistency of rules. All qualities for this business process currently are at a level 1.

**Figure 48: Current and Future Maturity Levels by Quality: Manage RI Medicaid Rate Setting**



### **11.5.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Manage RI Medicaid Rate Setting business process:

#### **Strategic Planning Influences**

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.<sup>172</sup>
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This may include enhancements to rate-setting methods.<sup>173</sup>

#### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

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<sup>172</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>173</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

## 11.5.4 Expected Characteristics

### 5-Year View

Accuracy and consistency of data used in the Manage RI Medicaid Rate Setting business process will support a level 2 within 5 years.

Improvements in the rate setting process, including automation, results in more accurate rates that encourage provider participation while helping to maintain cost controls. Hospital cost reports will be submitted through web portals or other forms of EDI. Standardization of data will increase efficiencies and allow staff to focus on program analysis.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. All capabilities for this business process are currently at a level 1 maturity.**

The table below summarizes the capability levels for the Manage RI Medicaid Rate Setting business process that are targeted over the next 5 years.

### 10-Year View

All capabilities of the Manage RI Medicaid Rate Setting business process will mature to a level 3 in 5 years with the automation of rates and consistency in rules.

Manual processing will be eliminated and replaced by automated business rules that access various clinical and operational data in order to automatically calculate the rates. Updates will be automatically processed so that data sharing partners will receive immediate notification of the new rates. Use of standardized business rules as well as data sharing standards will improve consistency of this process.

The table below summarizes the capability improvements for the Manage RI Medicaid Rate Setting business process that are targeted 5-10 years from now.

**Table 48: Future Maturity Level by MITA Quality: Manage RI Medicaid Rate Setting**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The process is a mix of manual and automated activities. Information is received from multiple sources.	2	The process is primarily automated. Messages are exchanged with trading partners to obtain information.	3
<b>Timeliness</b>	Increased automation shortens the time required to complete rate setting functions, improving timeliness over Level 1.	2	Use of MITA standard interface and data standards further reduces time required for rate setting, improving timeliness over Level 2.	3
<b>Data Access &amp; Accuracy</b>	Accuracy and consistency of data used in the process improves over Level 1 due to increased automation and HIPAA and other data standards.	2	Use of MITA standardized interfaces and data standards ensures accuracy of data. Data accuracy is measured as 99%.	3
<b>Effort to Perform</b>	Use of automation, HIPAA, and other data standards increase efficiency over Level 1.	2	Use of MITA standard data improves comparability of data used in the setting of rates. Automation allows staff to focus on strategic aspects of rate setting and Medicaid enterprise policy regarding rates.	3
<b>Cost Effectiveness</b>	Automation and HIPAA and other data standards increase cost-effectiveness over Level 1.	2	The process demonstrates improvement value projected by the Medicaid enterprise. Use of data standards in researching and analyzing rate data results in development of appropriate rates using appropriate resources.	3
<b>Accuracy of Process</b>	Improvements in the rate setting process, including automation, results in more accurate rates that encourage provider participation while helping to maintain cost controls.	2	Use of MITA standards improves ability to compare information used in rate setting with other data which in turn further improves the appropriateness of State rates.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Value to Stakeholders</b>	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1. (No change from the Current View)	2	Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	3

## 11.6 Develop Agency Goals and Objectives

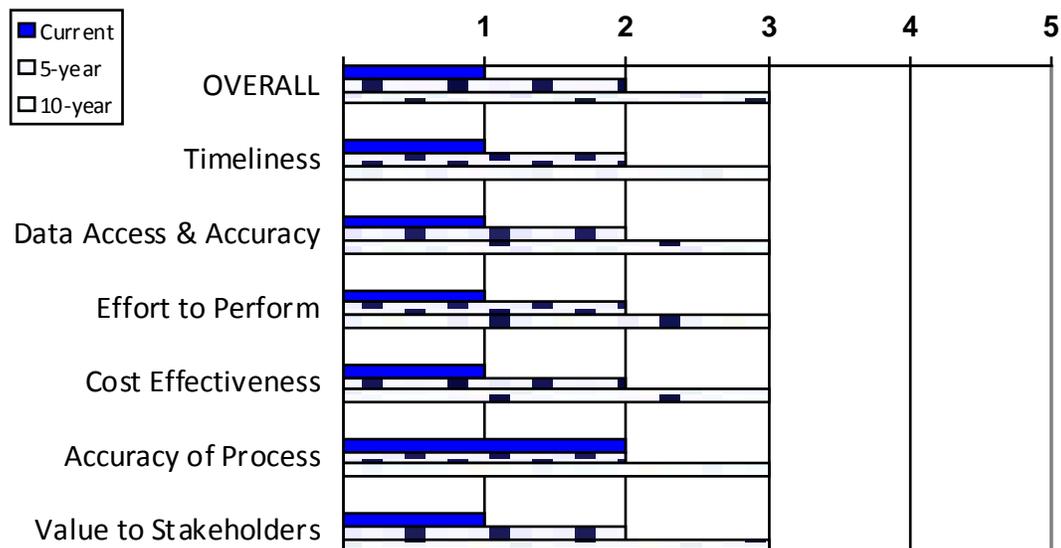
### 11.6.1 MITA Business Process Model

- Program Management: PG2 Develop Agency Goals and Objectives

### 11.6.2 Future Capability Overview

As shown in the figure below, the Develop Agency Goals and Objectives business process will be at a capability level 2 within 5 years. Within 10 years, this process will be at a level 3 with the use of MITA standard definitions to facilitate the ability to access data, analyze, formulate, communicate and distribute information on goals and objectives. Brainstorming using Webinar and automated collaboration enables State-wide input to the goal setting process. Most qualities for this business process currently are at a level 1.

**Figure 49: Current and Future Maturity Levels by Quality: Develop Agency Goals and Objectives**



### **11.6.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Develop Agency Goals and Objectives business process:

#### **Strategic Planning Influences**

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.<sup>174</sup>
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This includes maximizing available service options.<sup>175</sup>
- Improving health outcomes through more organized care is a goal of the Global Waiver Demonstration. Aspects of this goal include enhanced access to preventive care and improved management of patients with complex medical conditions. This business process is instrumental to the planning efforts associated with these aspects.<sup>176</sup>

#### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-

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<sup>174</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>175</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>176</sup> *ibid*

related components of this system and are critical to the efficient operation of this business process.

- Standardized tracking of prospective policy changes is not currently a priority for the department.

## 11.6.4 Expected Characteristics

### 5-Year View

All capabilities of the Develop Agency Goals and Objectives business process will mature to a level 2 in 5 years with some automation and tools used to gather, record, analyze, formulate, communicate and distribute information on goals and objectives to agency leadership and other state agencies.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. All capabilities for this business process are currently at a level 1 maturity.**

The table below summarizes the capability levels for the Develop Agency Goals and Objectives business process that are targeted over the next 5 years.

### 10-Year View

Within 10 years this process is fully engaged in a standard methodology to ensure that the organization is on track with the goals and objectives of the agency and is in concert with the Medicaid Enterprise and state-wide goals. MITA standard interfaces are used.

The table below summarizes the capability levels for the Develop Agency Goals and Objectives business process that are targeted 5-10 years from now.

**Table 49: Future Maturity Level by MITA Quality: Develop Agency Goals and Objectives**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The agency has implemented the use of a methodology to support development of goals and objectives.	2	This process is fully engaged in a standard methodology to ensure that the organization is on track with the goals and objectives of the agency and is in concert with the Medicaid Enterprise and state-wide goals	3
<b>Timeliness</b>	Implementation of standard methodologies leads to the more frequent review and modification of the goals and objectives. This also imposes traceability throughout the organization to ensure that the activities of the	2	The agency can develop, modify, track, and report on the goals and objectives in generally less than one week.	3
<b>Data Access &amp; Accuracy</b>	Standard methodology is implemented that provides guidance as to the level of detail necessary in the development of the goals and objectives. This also provides guidance for gathering the appropriate information from other	2	Goals and objectives can be measured and are more accurate, applicable, and traceable than at Level 2.	3
<b>Effort to Perform</b>	Because the process is standardized, efficiency can be measured and the information gathered is more complete and accurate. Process is seen as more efficient than at Level 1.	2	The development of goals and objectives is more efficient and maintenance is performed more frequently as the goals and objectives are incorporated into the operations. Efficiency improves over Level 2.	3
<b>Cost Effectiveness</b>	Standardization reduces the cost of development of goals and objectives as the quality increases.	2	The goals and objectives are cost effective and the results are accurate, dependable, traceable, and easy to maintain.	3
<b>Accuracy of Process</b>	Standardized methodologies produce goals and objectives that are easily traceable throughout the organization. (No Change from the Current View)	2	The goals and objectives are connected to every part of the Medicaid enterprise and other state agencies.	3
<b>Value to Stakeholders</b>	Standardization has provided clear and more useful information for stakeholders increasing satisfaction over Level 1.	2	Stakeholders collaborate in development of the goals and objectives for the Medicaid enterprise, further increasing stakeholder satisfaction over Level 2.	3

## 11.7 Develop and Maintain Program Policy

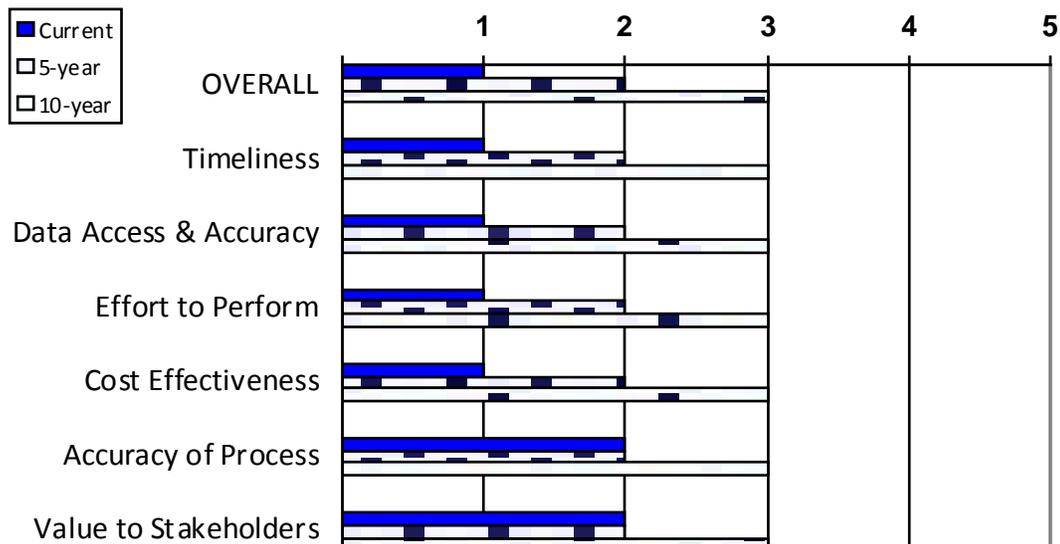
### 11.7.1 MITA Business Process Model

- Program Management: PG2 Develop and Maintain Program Policy

### 11.7.2 Future Capability Overview

As shown in the figure below, the Develop and Maintain Program Policy business process will be at an overall capability level 2 within the next 5 years. Within 10 years, all aspects of this process will be at a level 3, with standard interfaces to facilitate automation and collaboration among other department where possible. Most qualities for this business process currently are at a level 1.

**Figure 50: Current and Future Maturity Levels by Quality: Develop and Maintain Program Policy**



### **11.7.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Develop and Maintain Program Policy business process:

#### **Strategic Planning Influences**

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.<sup>177</sup>
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This may include enhancements to managed care plan monitoring and rate-setting methods.<sup>178</sup>
- Improving health outcomes through more organized care is a goal of the Global Waiver Demonstration. An aspect of this goal is expected to include increased enrollment in Medicaid managed care plans.<sup>179</sup>

#### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

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<sup>177</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>178</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>179</sup> *ibid*

- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which necessitate the evaluation of new and emerging technologies and treatments in health care.
- Under the Global Waiver, the goal to stimulate innovation and adoption of best practices.<sup>180</sup>
- Standardized tracking of prospective policy changes is not currently a priority for the department.

#### 11.7.4 Expected Characteristics

##### 5-Year View

Increased automation and use of tool to gather, record, communicate, and distribute information to the Medicaid Enterprise will support a level 2 capability within 5 years. The Department has implemented the use of a methodology to assist in the development and maintenance of program policy.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. All Currently, most aspects of this business process are manual, and therefore rated at a level 1 capability.**

The table below summarizes the capabilities for the Develop and Maintain Program Policy business process for the next 5 years.

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<sup>180</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

### 10-Year View

Immediate data availability and use of automated tools in program policy design, including access to clinical data, will support a level 3 capability for this business process within 10 years.

The concept of “Desktop Policy Making” and the ability for the department to use predictive modeling techniques to model policy changes will enable more flexibility. Program policy design will focus more on preventive care, and the emerging availability of clinical data will supplement paid claims data for analytic support.

The table below summarizes the capability improvements for the Develop and Maintain Program Policy business process that are targeted 5-10 years from now.

**Table 50: Future Maturity Level by MITA Quality: Develop and Maintain Program Policy**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The program policy is developed and/or maintained with collaboration from other agencies which encourages flexibility.	2	This process is fully adaptable to change with the use of methodologies to track the progress of development and maintenance of program policy and its results.	3
<b>Timeliness</b>	Implementation of standard methodologies introduces the more frequent review and modification of the program policy.	2	Program policy is an integral part of the agency’s operations. The agency can develop, modify, track, and report on the status of the program policy in less time than at Level 2.	3
<b>Data Access &amp; Accuracy</b>	Some automation of the information gathered for development of maintenance of the program policy improves accuracy.	2	Further automation and adoption of MITA data standards improves information gathered for the development and maintenance of the program policy resulting in increased accuracy of the data over Level 2.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Effort to Perform</b>	Efficiency is increased as the process is standardized and the information gathered is more complete and accurate.	2	The development and maintenance of program policy is efficient and maintenance is performed more frequently as the program policy is incorporated into operations.	3
<b>Cost Effectiveness</b>	Standardization reduces the cost of the development of program policy as the quality of the process increases.	2	Due to MITA standards, the program policy development and maintenance is cost effective and the results are accurate, dependable, traceable, and easy to maintain.	3
<b>Accuracy of Process</b>	More consistency in decision making/rules/validation. (No change from the Current View)	2	The development and maintenance of the program policy process is connected to every part of the Medicaid enterprise and other state agencies.	3
<b>Value to Stakeholders</b>	Standardization has provided clearer and more useful information for stakeholders resulting in increased stakeholder satisfaction over Level 1. (No change from the Current View)	2	Stakeholders are able to measure the impact of program policy increasing satisfaction over Level 2.	3

## 11.8 Maintain State Plan

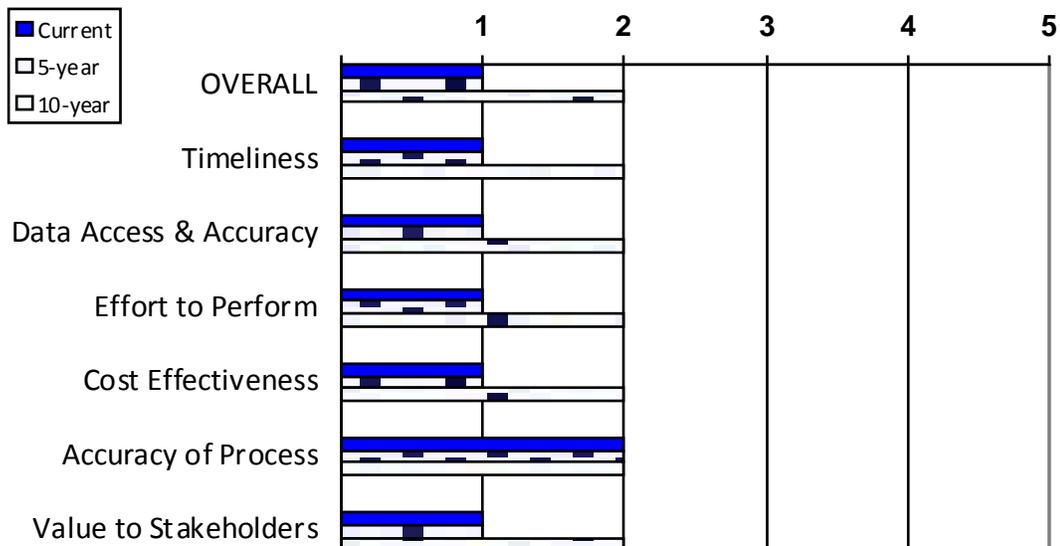
### 11.8.1 MITA Business Process Model

- Program Management: PG2 Maintain State Plan

### 11.8.2 Future Capability Overview

As shown in the figure below, the Maintain State Plan business process will remain at an overall capability level 1 over the next 5 years. Within 10 years, this process will be at an overall maturity level 2, with a mixture of manual and automated processes to support the Maintain State Plan business process. Most qualities for this business process currently are at a level 1.

Figure 51: Current and Future Maturity Levels by Quality: Maintain State Plan



### **11.8.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Maintain State Plan business process:

#### **Strategic Planning Influences**

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims as well as determination of eligibility.<sup>181</sup>
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This may include enhancements to managed care plan monitoring and rate-setting methods.<sup>182</sup>
- Improving health outcomes through more organized care is a goal of the Global Waiver Demonstration. An aspect of this goal is expected to include increased enrollment in Medicaid managed care plans.<sup>183</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create mechanisms that support the Department's goal of rewarding improved plan performance.<sup>184</sup>

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<sup>181</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

<sup>182</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>183</sup> *ibid*

<sup>184</sup> *ibid*

## Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.
- Under the Global Waiver, the goal to stimulate innovation and adoption of best practices.<sup>185</sup>

### 11.8.4 Expected Characteristics

#### 5-Year View

The maturity level of the current view for the Maintain State Plan business process is not expected to change in the next 5 years.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. There are no major initiatives currently underway that are expected to improve the maturity of this business process in the next 5 years. Current capabilities for most qualities are at Level 1.**

The table below summarizes the capabilities for the Maintain State Plan business process for the next 5 years.

#### 10-Year View

The Department has developed standard methodologies and information centralization to respond to changes in the State Plan. State Plan resides on the State's portal for configuration and version control management. Electronic updates to the State Plan are easier to adapt to change.

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<sup>185</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

The table below summarizes the capability improvements for the Maintain State Plan business process that are targeted 5-10 years from now.

**Table 51: Future Maturity Level by MITA Quality: Maintain State Plan**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The process is primarily a manual function. (No change from the Current View)	1	The process is a mixture of manual and automated and/or electronic functions. The base document and updates are stored electronically and are transmitted to CMS.	2
<b>Timeliness</b>	All updates are manual and difficult to implement. Maintenance of State Plan is a year-round activity. (No change from the Current View)	1	The electronic State Plan can be updated as necessary.	2
<b>Data Access &amp; Accuracy</b>	The manual nature of this process increases the risk of unreliable and inaccurate information. (No change from the Current View)	1	Implementation of standardized methodologies and centralized data allow for more accurate information.	2
<b>Effort to Perform</b>	Process meets state objectives for maintaining State Plan. (No change from the Current View)	1	Electronic creation and versioning provides more efficient maintenance of the State Plan.	2
<b>Cost Effectiveness</b>	This is a manual effort and requires time and effort to complete. Cost to benefit ratio is relatively high. (No change from the Current View)	1	A mixture of manual and automated processes reduces the effort to maintain the State Plan as compared to Level 1. Cost to benefit ratio improves over Level 1.	2
<b>Accuracy of Process</b>	Updates are better controlled, more timely, and accurate as compared to Level 1. (No change from the Current View)	2	Updates are better controlled, more timely, and accurate as compared to Level 1. (No change from the 5- year View)	2

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Value to Stakeholders</b>	Stakeholder satisfaction is negatively impacted by manual processes, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction. (No change from the Current View)	1	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	2

## 11.9 Manage State Funds

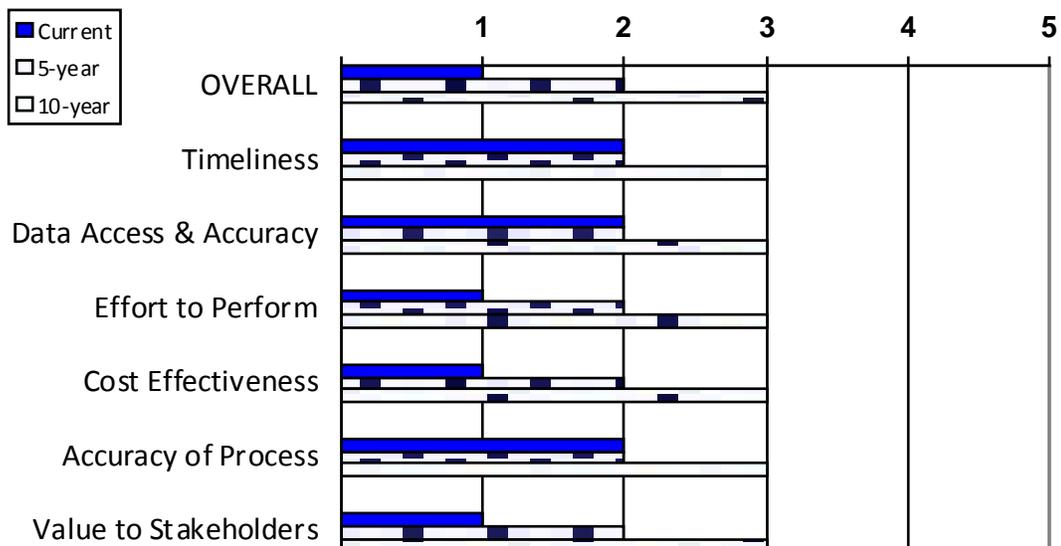
### 11.9.1 MITA Business Process Model

- Program Management: PG3 Manage State Funds

### 11.9.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage State Funds business process will be at a capability level 2 within next 5 years. Within 10 years, all aspects of this process will be at a level 3, with the process being primarily automated due to improvements in COTS products and use of MITA standardized data. Qualities for this business process currently are split between a level 1 and level 2.

Figure 52: Current and Future Maturity Levels by Quality: Manage State Funds



### **11.9.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Manage State Funds business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to manage the financial stability of the program.<sup>186</sup>
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration.<sup>187</sup>
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>188</sup>
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal

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<sup>186</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>187</sup> *ibid*

<sup>188</sup> *ibid*

Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.<sup>189</sup>

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the Department's budgeting and accounting functions.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the need for Federal and State financial participation.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>190</sup>
- Under the Global Waiver, the goal to stimulate innovation and adoption of best practices.<sup>191</sup>
- Under the Global Waiver, the goal to disclose information about reimbursement rates and payments on a regular basis.<sup>192</sup>

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<sup>189</sup> U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

<sup>190</sup> Gary Alexander/Elena Niclolla, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>191</sup> *ibid*

<sup>192</sup> *ibid*, Slide 6

## 11.9.4 Expected Characteristics

### 5-Year View

All aspects of the Manage State Funds business process will be at a capability level 2 within the next 5 years. Improvements in automation will allow staff to focus on analysis of state funds.

**This business process is not expected to be at Level 3 within 5 years. Although qualities currently are split between a level 1 and level 2, there are no major near-term initiatives that are expected to significantly improve the capabilities related to this business process.**

The table below summarizes the capability improvements for the Manage State Funds business process that are targeted over the next 5 years.

### 10-Year View

Within 5 to 10 years, this process will be primarily automated due to improvements such as the use of COTS products and standardization of data. MITA aligned Service Level Agreements with other agencies improve collaboration.

The table below summarizes the capability improvements for the Manage State Funds business process that are targeted 5-10 years from now.

**Table 52: Future Maturity Level by MITA Quality: Manage State Funds**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	A mixture of manual and automated process is used.	2	The process is primarily automated due to improvements in COTS products and use of MITA standardized data.	3
<b>Timeliness</b>	Less time is required than Level 1. (No change from the Current View)	2	The process takes less time than Level 2.	3
<b>Data Access &amp; Accuracy</b>	Some automation improves accuracy and reduces errors. (No change from the Current View)	2	Use of MITA standard interface further improves accuracy.	3
<b>Effort to Perform</b>	Automated processes results in improvements in utilization of staff who are proactively managing state funds.	2	Efficiency improves further through use of MITA standard interface which ensures consistency among the various State funds.	3
<b>Cost Effectiveness</b>	Automation frees some time for staff to focus on analysis of the data, projections, and recommendations for improvements in allocation formulas.	2	MITA standard interfaces and improvements in COTS further increase the cost-effectiveness over Level 2.	3
<b>Accuracy of Process</b>	Automation reduces error rates and makes it easier to detect and correct errors. (No change from the Current View)	2	MITA standard interfaces further increase the accuracy over Level 2.	3
<b>Value to Stakeholders</b>	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	2	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities.	3

## 11.10 Formulate Budget

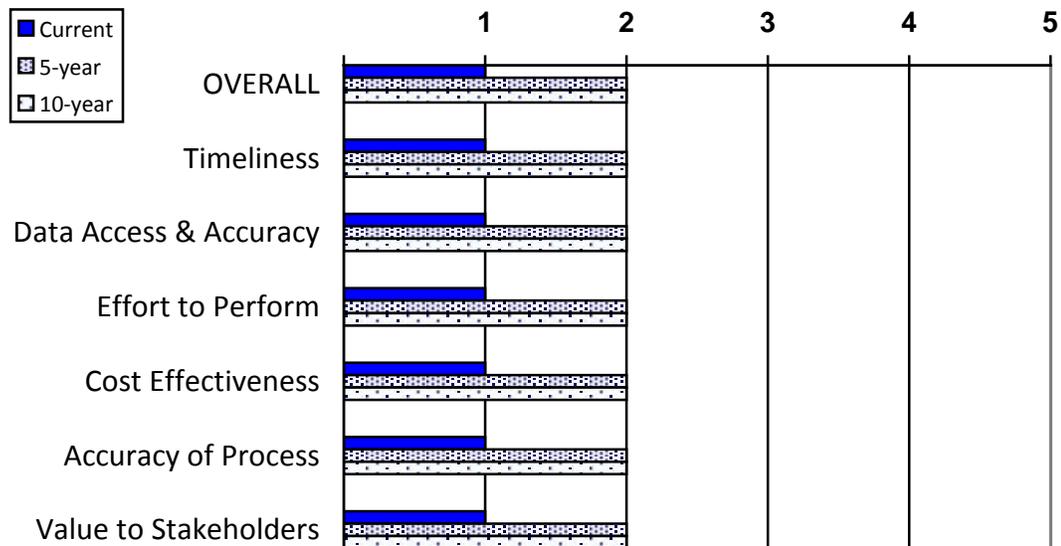
### 11.10.1 MITA Business Process Model

- Program Management: PG3 Formulate Budget

### 11.10.2 Future Capability Overview

As shown in the figure below, the Formulate Budget business process will be at a capability level 2 within the next 5 years, with collaboration among stakeholders and other agencies to develop an enterprise-wide budget. This business process will remain at a level 2 capability within 10 years with the DHS focus on other areas of the Medicaid program. All qualities for this business process currently are at a level 1.

Figure 53: Current and Future Maturity Levels by Quality: Formulate Budget



### **11.10.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Formulate Budget business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to manage the financial stability of the program.<sup>193</sup>
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration.<sup>194</sup>
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>195</sup>
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal

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<sup>193</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>194</sup> *ibid*

<sup>195</sup> *ibid*

Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.<sup>196</sup>

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the Department's budgeting and accounting functions.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the need for Federal and State financial participation.
- EOHHS Modernization goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>197</sup>
- Under the Global Waiver, the goal to stimulate innovation and adoption of best practices.<sup>198</sup>
- Under the Global Waiver, the goal to disclose information about reimbursement rates and payments on a regular basis.<sup>199</sup>

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<sup>196</sup> U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

<sup>197</sup> Gary Alexander/Elena Niclolla, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>198</sup> *ibid*

<sup>199</sup> *Ibid*, Slide 6

## 11.10.4 Expected Characteristics

### 5-Year View

With a mixture of automation and manual intervention to gather and verify financial information and cost projections, the Formulate Budget business process will be at a capability level 2 over the next 5 years. The planned enhancements to the MMIS will allow for currently non-MMIS payments to now be included in the MMIS and support automation of reporting of expenditures.

**This business process is not expected to be at Level 3 within 5 years. All qualities currently are at a Level 1.**

The table below summarizes the capability improvements for the Formulate Budget business process that are targeted over the next 5 years.

### 10-Year View

This business process will remain at a level 2 capability within 10 years. The Department's focus on other areas of MITA maturity will defer resources from achieving increased capabilities within the Formulate Budget business process.

**Table 53: Future Maturity Level by MITA Quality: Formulate Budget**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The process is a mixture of automation and manual intervention to gather and verify financial information and cost projections.	2	No change from the 5 year view	2
<b>Timeliness</b>	Monitoring and updates to the budget occur daily. Automation improves timeliness of updates over Level 1.	2	No change from the 5 year view	2

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Data Access &amp; Accuracy</b>	The information is gathered from financial cost data and from the DSS. Automation of data capture and availability of predictive modeling and forecasting tools improves accuracy.	2	No change from the 5 year view	2
<b>Effort to Perform</b>	Electronic creation and versioning provides more efficient formulation of the budget.	2	No change from the 5 year view	2
<b>Cost Effectiveness</b>	A mixture of manual and automated processes reduces the effort to formulate the budget as compared to Level 1. Cost to benefit ratio improves over Level 1	2	No change from the 5 year view	2
<b>Accuracy of Process</b>	Increased automation improves accuracy of data extracted from systems and accuracy of predictive modeling and forecasting tools.	2	No change from the 5 year view	2
<b>Value to Stakeholders</b>	Standardized COTS predictive modeling and forecasting tools for calculating and forecasting improves timeliness and accuracy of budget outcome and improves the ability of staff to carry out process.	2	No change from the 5 year view	2

## 11.11 Manage FFP for MMIS

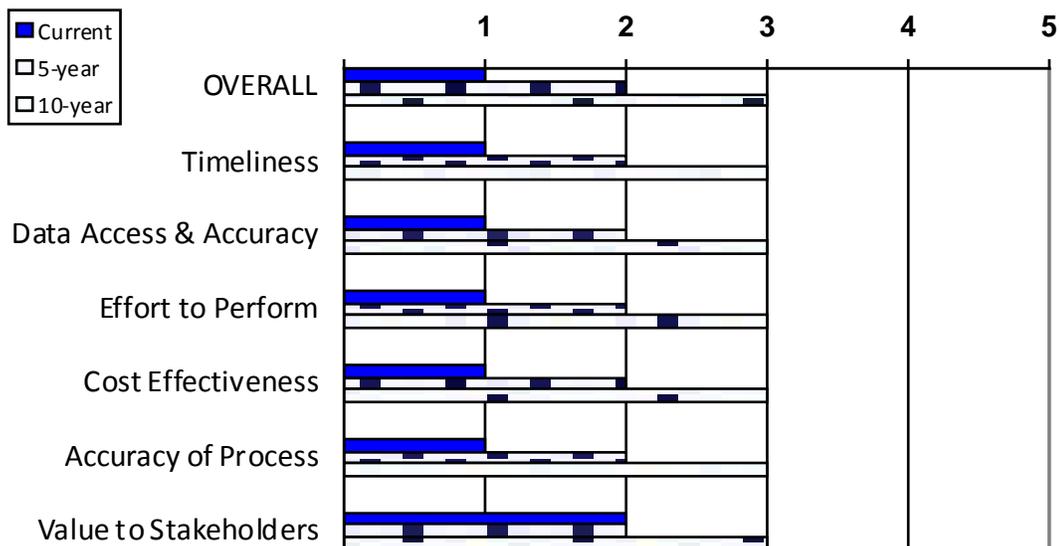
### 11.11.1 MITA Business Process Model

- Program Management: PG3 Manage FFP for MMIS

### 11.11.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage FFP for MMIS business process will be at a capability level 2 in 5 years, where the State has implemented standard methodologies to enable organized development and management of FFP reporting requirements. Within 10 years, all aspects of this process will be at a level 3. At this level, the Department has automated most activities to the extent feasible and uses MITA standard interfaces. Most qualities for this business process currently are at a level 1.

**Figure 54: Current and Future Maturity Levels by Quality: Manage FFP for MMIS**



### **11.11.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Manage FFP for MMIS business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to manage the financial stability of the program.<sup>200</sup>
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration.<sup>201</sup>
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>202</sup>
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal

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<sup>200</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>201</sup> *ibid*

<sup>202</sup> *ibid*

Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.<sup>203</sup>

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the Department's budgeting and accounting functions.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the need for Federal and State financial participation.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>204</sup>
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.<sup>205</sup>

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<sup>203</sup> U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

<sup>204</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>205</sup> Ibid, Slide 6

#### 11.11.4 Expected Characteristics

##### 5-Year View

With the increased automation in the storage and retrieval of data regarding costs for DDI or operation of the MMIS and preparation of the data needed to request Federal Funding Participation (FFP) or write an Advance Planning Document (APD), the Manage FFP for MMIS business process will be at a capability level 2 within 5 years.

The business process will increase its use of electronic interchange and automated processes (e.g., OCR for paper transactions). Communication related to managing FFP will be increasingly coordinated between programs and agencies.

**This Medicaid business process is not expected to be at Level 3 within 5 years. Most qualities currently are at a Level 1, and major improvements likely will be tied to the enhancements to the MMIS (targeted for the latter part of the 5-year view).**

The table below summarizes the capability improvements for the Manage FFP for MMIS business process that are targeted over the next 5 years

##### 10-Year View

At this level, programs are agile and able to adjust business rules quickly in response to Medicaid changes and when output monitoring indicates that the business rules are no longer yielding desired results. This flexibility will support a level 3 capability for this business process within 10 years.

Data centralization and standardization is in place providing more fully automated and accurate information to manage the reporting of FFP for MMIS. Accuracy is measured at 98% or better.

The table below summarizes the capability improvements for the Manage FFP for MMIS business process that are targeted 5-10 years from now

**Table 54: Future Maturity Level by MITA Quality: Manage FFP for MMIS**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	State has implemented standard methodologies to enable organized development and management of FFP reporting requirements.	2	The process uses MITA standard interface for extracting data and producing results.	3
<b>Timeliness</b>	The Medicaid enterprise has implemented centralization and standardization of the information needed to manage computation of the FFP for MMIS. Process requires less time than Level 1.	2	Use of MITA standard interfaces streamlines access to data and computations needed to produce data for reporting of FFP for MMIS. Produces useful output in 8 hours or less.	3
<b>Data Access &amp; Accuracy</b>	Data centralization and standardization provide more accurate information to manage the reporting of FFP for MMIS.	2	Data centralization and standardization is in place providing more fully automated and accurate information to manage the reporting of FFP for MMIS. Accuracy is measured at 98% or better.	3
<b>Effort to Perform</b>	The data centralization and standardization of the information increases the efficiency of documenting FFP for MMIS.	2	Data centralization and use of MITA standard interfaces provide a more efficient and streamlined process for the management of the FFP for MMIS over Level 2.	3
<b>Cost Effectiveness</b>	The centralization and standardization of the information and automation of access reduce the effort of documenting the FFP for MMIS.	2	Data centralization and use of MITA standard interfaces provide a cost effective and streamlined process for documenting the FFP for MMIS.	3
<b>Accuracy of Process</b>	The data centralization and standardization of the information increases the accuracy of the data used in managing the FFP and the error rates are reduced.	2	Data centralization and use of MITA standard interfaces provide an accurate and streamlined process for managing the FFP for MMIS. The error rates are less than 2%.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Value to Stakeholders</b>	Medicaid Enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. (No change from the View)	2	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities.	3

## 11.12 Manage FMAP

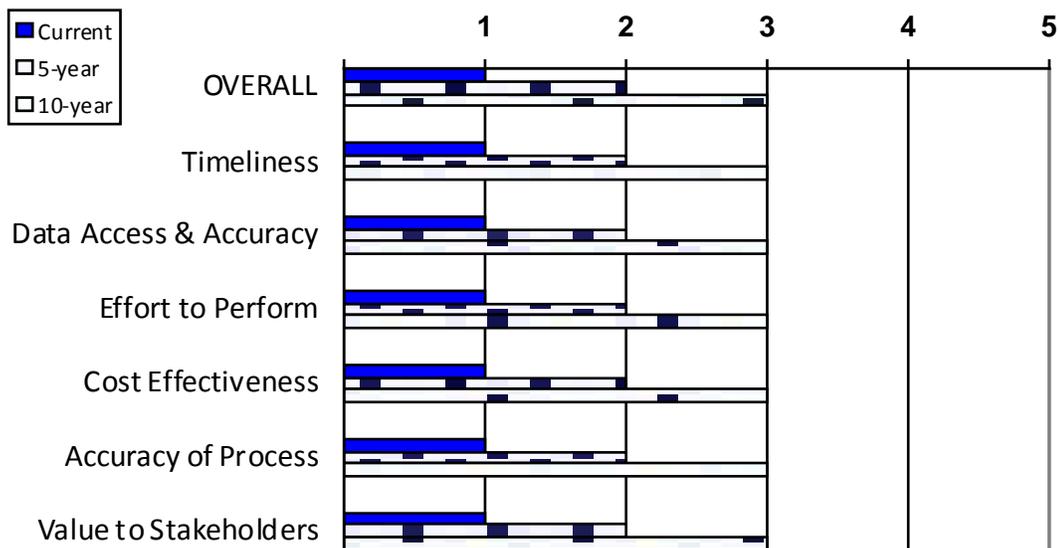
### 11.12.1 MITA Business Process Model

- Program Management: PG3 Manage FMAP

### 11.12.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage FMAP business process will be at a capability level 2 in 5 years, where the process uses a mix of manual and automated activities to develop, maintain, and monitor rules used to assign the correct FMAP rate to service expenditures and recoveries. Within 10 years, all aspects of this process will be at a level 3, where the process is primarily automated based on Department policies for assigning FMAP rates. All qualities for this business process currently are at a level 1.

Figure 55: Current and Future Maturity Levels by Quality: Manage FMAP



### **11.12.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Manage FMAP business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to manage the financial stability of the program.<sup>206</sup>
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration.<sup>207</sup>
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>208</sup>
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal

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<sup>206</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>207</sup> *ibid*

<sup>208</sup> *ibid*

Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.<sup>209</sup>

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the Department's budgeting and accounting functions.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the need for Federal and State financial participation.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>210</sup>
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.<sup>211</sup>

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<sup>209</sup> U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

<sup>210</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>211</sup> Ibid, Slide 6

#### 11.12.4 Expected Characteristics

##### 5-Year View

With induction of some automation, the Manage FMAP business process will be at a capability level 2 within 5 years. Automation and coordination of processes will enable staff to focus more on member and provider management.

**This Medicaid business process is not expected to be at Level 3 within 5 years. All qualities currently are at a Level 1. In addition, major improvements to this business process are not expected until after the enhancements to the new MMIS (targeted for the latter half of the 5-year view).**

The table below summarizes the capability improvements for the Manage FMAP business process that are targeted over the next 5 years

##### 10-Year View

Use of data sharing standards and almost complete elimination of non-electronic data exchanges will support a level 3 capability for this business process within 10 years.

Interagency collaboration, use of data sharing standards, and regional electronic information exchange will improve timeliness of communication and reporting. Standardized queries and automated alerts will help distribute updates to data sharing partners.

Stakeholders will experience seamless and efficient program communications no matter how or where they contact the Department. Due to increased efficiency, staff can be redirected to more productive tasks, including program and contractor quality improvement.

The table below summarizes the capability improvements for the Manage FMAP business process that are targeted 5-10 years from now.

**Table 55: Future Maturity Level by MITA Quality: Manage FMAP**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The process uses a mix of manual and automated activities to develop, maintain, and monitor rules used to assign the correct FMAP rate to service expenditures and recoveries.	2	<b>The process is primarily automated based on Medicaid enterprise policies for assigning FMAP rates.</b>	3
<b>Timeliness</b>	The process improves on timeliness of automated access to analyze information.	2	The process further improves on timeliness through use of MITA standard interface data as the basis for determining the correct FMAP.	3
<b>Data Access &amp; Accuracy</b>	Enhanced data definitions, through collaborations of Stakeholders, improve accuracy of data used to assign FMAP rates.	2	Use of MITA standardized interfaces and data definitions maximizes accuracy of data.	3
<b>Effort to Perform</b>	Introduction of automated processes results in improved efficiency.	2	Due to MITA standard interfaces, efficiency further increases over Level 2.	3
<b>Cost Effectiveness</b>	The process meets State cost containment guidelines due to introduction of standards and automation.	2	The process demonstrates the improvement value projected by the Medicaid enterprise due to MITA standard interfaces.	3
<b>Accuracy of Process</b>	Accuracy of results improves through automation and standardized data.	2	Monitoring of the results is built in to the process. MITA standard interfaces increase accuracy and usefulness of the result over Level 2.	3
<b>Value to Stakeholders</b>	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	2	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities.	3

## 11.13 Manage 1099s

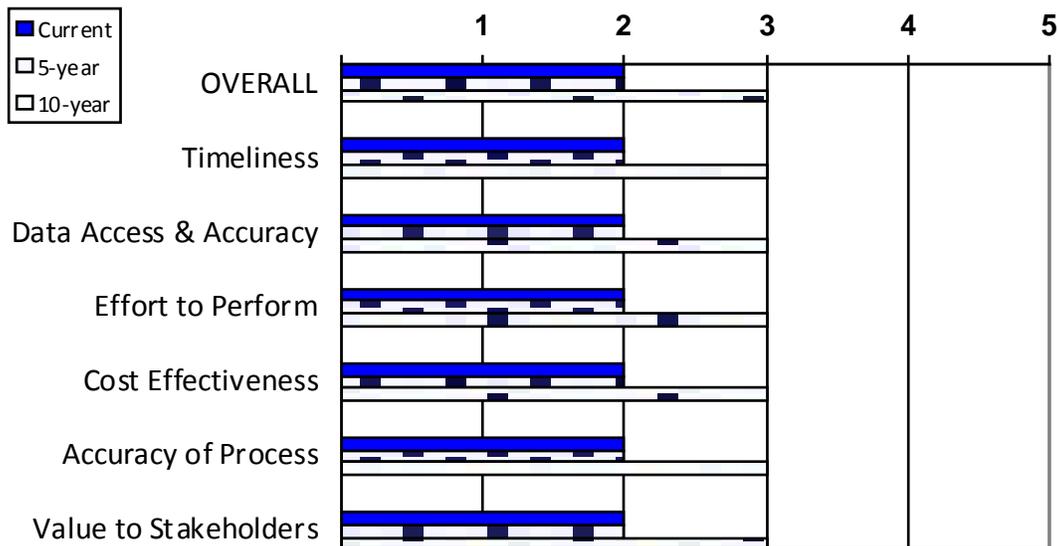
### 11.13.1 MITA Business Process Model

- Program Management: PG4 Manage 1099s

### 11.13.2 Future Capability Overview

As shown in the figure below, the Manage 1099s business process will remain at a capability level 2 over the next 5 years. Within 10 years, all aspects of this process will be at a level 3, with the processing fully automated with standard interfaces. All qualities for this business process currently are at a level 2

Figure 56: Current and Future Maturity Levels by Quality: Manage 1099s



### **11.13.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Manage 1099s business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to manage the financial stability of the program.<sup>212</sup>

#### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the Department's budgeting and accounting functions.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>213</sup>
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.<sup>214</sup>

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<sup>212</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>213</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>214</sup> Ibid, Slide 6

#### 11.13.4 Expected Characteristics

##### 5-Year View

The Manage 1099s business process will remain at a capability level 2 over the next 5 years.

**This business process is not expected to be at Level 3 within 5 years. All qualities for this business process currently are at a Level 2. No major near-term initiatives are underway that are expected to greatly impact this business process.**

The table below summarizes the capability levels for the Manage 1099s business process over the next 5 years.

##### 10-Year View

Increased automation and standardization of the Manage 1099s business process will support a level 3 capability within 10 years.

The Manage 1099s business process, in 10 years will be fully automated with rare exceptions. The process will utilize MITA standard interfaces and the federal standard format for the electronic 1099.

The table below summarizes the capability improvements for the Manage 1099s business process that are targeted 5-10 years from now.

**Table 56: Future Maturity Level by MITA Quality: Manage 1099s**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The process uses a mix of manual and automated processes. (No change from the current view)	2	<b>The process is fully automated with rare exceptions.</b>	3
<b>Timeliness</b>	Meets goals for production of 1099s. Automation improves timeliness over Level 1. (No change from the current view)	2	Automation and the use of MITA standard interfaces increases timeliness over Level 2.	3
<b>Data Access &amp; Accuracy</b>	Error rate and corrections decrease due to increase in automation and inter-agency agreements. (No change from the current view)	2	Information adheres to MITA standard interface specifications which improves accuracy over Level 2. Accuracy is measured at 98% or better.	3
<b>Effort to Perform</b>	Process is more efficient than at Level 1 due to automation. (No change from the current view)	2	Process is more efficient than Level 2 due to MITA standard interfaces.	3
<b>Cost Effectiveness</b>	Less effort is required increasing cost effectiveness over Level 1. (No change from the current view)	2	Less effort to produce 1099s is needed than at level 2, but more focus is on quality control.	3
<b>Accuracy of Process</b>	The process meets the Medicaid enterprise's goals for numbers of 1099s produced on schedule with reduced error rate. (No change from the current view)	2	The process meets to Medicaid enterprise's goals for numbers of 1099s produced on schedule, inter-agency collaboration, and reduction in error rate.	3
<b>Value to Stakeholders</b>	Stakeholder satisfaction improves over Level 1, due to automation and resulting reduction in errors. (No change from the current view)	2	Stakeholders are more satisfied than at Level 2 due to the use of MITA standard interfaces increasing efficiency and accuracy.	3

## 11.14 Perform Accounting Functions

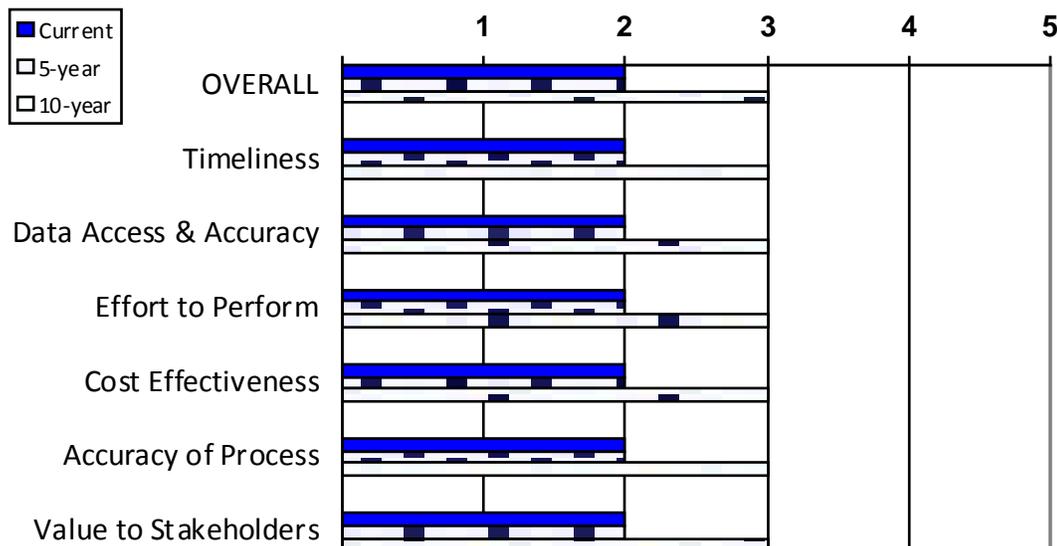
### 11.14.1 MITA Business Process Model

- Program Management: PG4 Perform Accounting Functions

### 11.14.2 Future Capability Overview

As shown in the figure below, the Perform Accounting Functions business process will remain at a capability level 2 over the next 5 years. Within 10 years, all aspects of this process will be at a level 3, with periodic reporting being highly automated. All qualities for this business process currently are at a level 2

**Figure 57: Current and Future Maturity Levels by Quality: Perform Accounting Functions**



### **11.14.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Perform Accounting Functions business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to manage the financial stability of the program.<sup>215</sup>
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration.<sup>216</sup>
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>217</sup>
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and

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<sup>215</sup> Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>216</sup> *ibid*

<sup>217</sup> *ibid*

certain parents) with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.<sup>218</sup>

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the Department's budgeting and accounting functions.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>219</sup>
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.<sup>220</sup>

### **11.14.4 Expected Characteristics**

#### **5-Year View**

The Perform Accounting Functions business process will remain at a capability level 2 over the next 5 years.

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<sup>218</sup> U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

<sup>219</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>220</sup> Ibid, Slide 6

**This business process is not expected to be at Level 3 within 5 years. All qualities for this business process currently are at a Level 2. No major near-term initiatives are underway that are expected to greatly impact this business process.**

The table below summarizes the capability levels for the Perform Accounting Functions business process over the next 5 years.

### 10-Year View

Increased automation and standardization of the Perform Accounting Functions business process will support a level 3 capability within 10 years.

The Perform Accounting business process, in 10 years will be fully automated. The process will comply with CFR 45, Cash Management Act, GASB standards and GAAP. Collaboration is further improved by the use of data definitions and MITA standard interfaces.

The table below summarizes the capability improvements for the Perform Accounting Functions business process that are targeted 5-10 years from now.

**Table 57: Future Maturity Level by MITA Quality: Perform Accounting Functions**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Complies with CFR 45, Cash Management Act, GASB standards and Generally Accepted Accounting Principles (GAAP) COTS packages are certified compliant with these standards. (No change from the current view)	2	<b>Complies with CFR 45, Cash Management Act, GASB standards and GAAP. Uses MITA standard interface.</b>	3
<b>Timeliness</b>	Less time is required than at Level 1. Automated processes. (No change from the current view)	2	Less time is required than at Level 2. Standard interface.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Data Access &amp; Accuracy</b>	Accuracy and consistency of data used in the process are improved due to the use standards and increased automation. (No change from the current view)	2	Use of MITA standardized interfaces and data definitions ensures even greater improvement in the accuracy of data.	3
<b>Effort to Perform</b>	Automated processes results in higher efficiency. (No change from the current view)	2	Meets Medicaid enterprise goals for improvement in efficiency and complies with MITA conformance standard for this process.	3
<b>Cost Effectiveness</b>	Through the use of automation and other process improvements, the cost benefit ratio improves. (No change from the current view)	2	The process demonstrates further improvement value desired by the Medicaid enterprise.	3
<b>Accuracy of Process</b>	Reduction in errors and improved consistency of results increase usefulness of the process. (No change from the current view)	2	Accuracy and consistency are further improved with use of MITA standard interface.	3
<b>Value to Stakeholders</b>	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1. (No change from the current view)	2	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities.	3

## 11.15 Develop and Manage RI Medicaid Performance Measures and Reporting

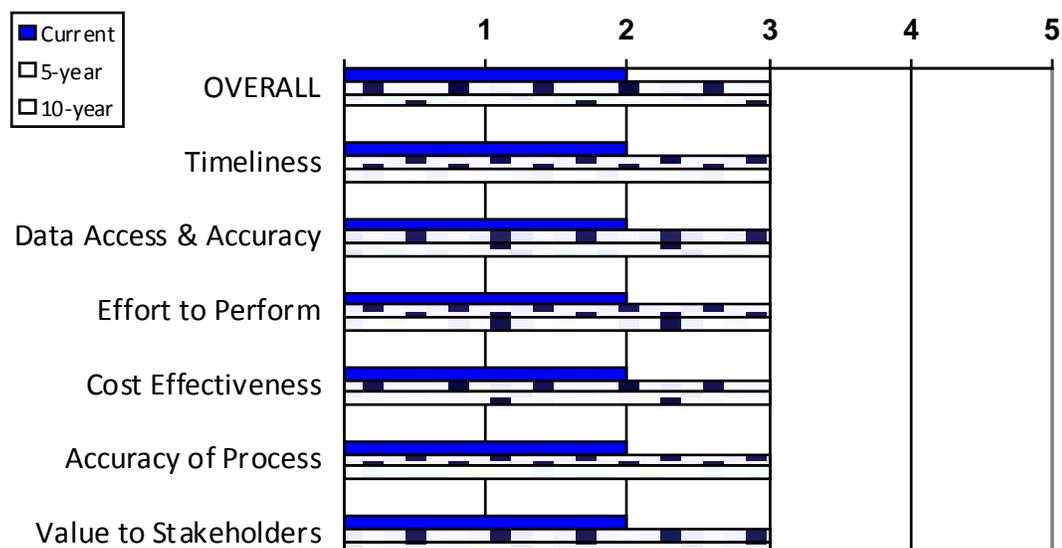
### 11.15.1 MITA Business Process Model

- Program Management: PG5 Develop and Manage Performance Measures and Reporting

### 11.15.2 Future Capability Overview

As shown in the figure below, all aspects of the Develop and Manage RI Medicaid Performance Measures and Reporting business process will be at a capability level 3 in 5 years. In 10 years, this process will remain at a level 3. All qualities for this business process currently are at a level 2

**Figure 58: Current and Future Maturity Levels by Quality: Develop and Manage RI Medicaid Performance Measures and Reporting**



### 11.15.3 Influences, Barriers and Facilitators

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Develop and Manage RI Medicaid Performance Measures and Reporting business process:

#### Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization.<sup>221</sup>
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>222</sup>
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for performance measuring and reporting.<sup>223</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create

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<sup>221</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>222</sup> *ibid*

<sup>223</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

mechanisms that support the Department’s goal of rewarding improved plan performance.<sup>224</sup>

- The Medicaid Director’s vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser. More enrollees in Managed Care will increase the volume of encounters and facilitate the need for cleaner, more accurate data.
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical “home” (e.g., PCP).
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring (e.g., creating new measures for the Seniors and Persons with Disabilities (SPD) population) may create capitation payment methods that support the Department’s goal of rewarding improved plan performance.

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the program management-related components of this system and are critical to the efficient operation of this business process.
- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.
- The method by which the Fiscal Agent receives encounter data is currently non-standard. There is data accuracy, integrity and timeliness issues with

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<sup>224</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

the current encounter data that impede the ability for the Department to utilize the encounter data for program management activities.

- A variety of incentives exist for health plans to submit timely and accurate encounter data. An encounter data component in the health plan capitation calculation provides health plans with an incentive to submit accurate, timely, and a consistent volume of data. HEDIS also provides incentive for health plans to process quality encounter data, including HEDIS awards. The ‘default algorithm’ is also another means of incentivizing health plans.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>225</sup>
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.<sup>226</sup>

#### **11.15.4 Expected Characteristics**

##### **5-Year View**

With the full automation of processes to gather data and perform calculated outcome measures, the Develop and Manage RI Medicaid Performance Measures and Reporting business process will be at a capability level 3 within 5 years.

The table below summarizes the capability improvements for the Develop and Manage RI Medicaid Performance Measures and Reporting business process that are targeted over the next 5 years.

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<sup>225</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>226</sup> Ibid, Slide 6

### 10-Year View

This business process will remain at a level 3 capability within 10 years. The Department focus on other areas of MITA maturity will defer resources from achieving increased capabilities within the Manage RI Medicaid Performance Measures and Reporting business process.

**Table 58: Future Maturity Level by MITA Quality: Develop and Manage RI Medicaid Performance Measures and Reporting**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The process uses MITA standardized interfaces and data definitions to standardize performance measures for all Medicaid enterprises and programs.	3	No change from the 5 year view	3
<b>Timeliness</b>	Information can be refreshed daily on dashboard. Periodicity of posting is up to the state.	3	No change from the 5 year view.	3
<b>Data Access &amp; Accuracy</b>	Performance measurement is built into individual business processes and also consolidated into state-level dashboards.	3	No change from the 5 year view.	3
<b>Effort to Perform</b>	Use of MITA standards increases efficiency of this process.	3	No change from the 5 year view.	3
<b>Cost Effectiveness</b>	Use of MITA standard interfaces and inclusion of performance measures in individual business processes increases cost-effectiveness of this process.	3	No change from the 5 year view.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Accuracy of Process</b>	Accuracy increases over level 2 due to the use of MITA standard interfaces.	3	No change from the 5 year view.	3
<b>Value to Stakeholders</b>	Medicaid enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities.	3	No change from the 5 year view.	3

## 11.16 Generate Financial and Program Analysis Report

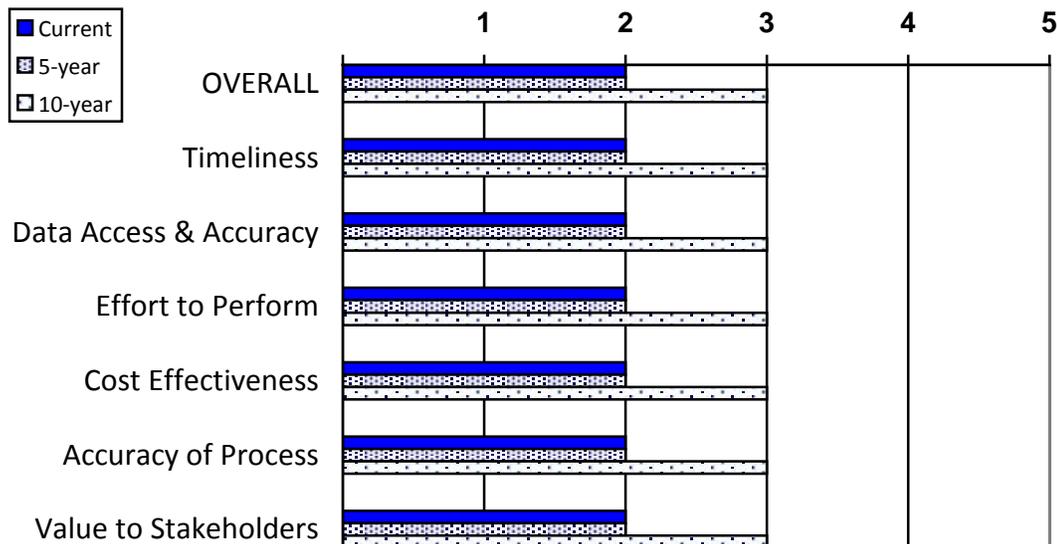
### 11.16.1 MITA Business Process Model

- Program Management: PG6 Generate Financial and Program Analysis Report

### 11.16.2 Future Capability Overview

As shown in the figure below, all aspects of the Generate Financial and Program Analysis Report business process will remain at a level 2 over the next 5 years. Within 10 years, the Generate Financial and Program Analysis Report business process will reach a level 3 with the process utilizing MITA standard interface specifications for automated electronic interchanges. The Department will support data interoperability. All qualities for this business process currently are at a level 2.

**Figure 59: Current and Future Maturity Levels by Quality: Generate Financial and Program Analysis Report**



### **11.16.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Generate Financial and Program Analysis Report business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to manage the financial stability of the program.<sup>227</sup>
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration.<sup>228</sup>
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>229</sup>
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and

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<sup>227</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>228</sup> *ibid*

<sup>229</sup> *ibid*

certain parents) with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.<sup>230</sup>

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the Department's budgeting and accounting functions.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity.<sup>231</sup>
- Under the Global Waiver goal to stimulate innovation and adoption of best practices.<sup>232</sup>
- EOHHS transparency goal to disclose information about reimbursement rates and payments on a regular basis.<sup>233</sup>

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<sup>230</sup> U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

<sup>231</sup> Gary Alexander/Elena Niclolla, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>232</sup> *ibid*

<sup>233</sup> *ibid*, Slide 6

#### 11.16.4 Expected Characteristics

##### 5-Year View

The Generate Financial and Program Analysis Report business process will remain at a level 2 over the next 5 years with generation of the financial and program analysis report generally taking less than a day. Use of standard interfaces further improves the accuracy of the data used in this process.

**This business process is not expected to be at Level 3 within 5 years. All qualities for this business process currently are at a Level 2, with no major initiatives underway to that are expected to greatly impact this function.**

The table below summarizes the capability improvements for the Generate Financial and Program Analysis Report business process that are targeted over the next 5 years.

##### 10-Year View

The Generate Financial and Program Analysis Report business process will reach a level 3 within 10 years with the use of fully automated rules and standardized data sharing.

Interoperability of data allows the Department to use information from other departments or entities in an efficient and effective manner to generate the Financial and Program Report more frequently.

The table below summarizes the capability improvements for the Generate Financial and Program Analysis Report business process that are targeted 5-10 years from now.

**Table 59: Future Maturity Level by MITA Quality: Generate Financial and Program Analysis Report**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	This business process uses a mix of manual and automated processes. (No change from the current view)	2	This business process is a fully automated process.	3
<b>Timeliness</b>	Standardization of data has reduced the time it takes to generate the financial and program analysis report to one month on the average. (No change from the current view)	2	The generation of the financial and program analysis report generally takes less than a day. Information can be retrieved at any time through “dash boards”.	3
<b>Data Access &amp; Accuracy</b>	Standard methodologies have defined the non- centrally located sources for the information needed to generate the financial and program analysis report. (No change from the current view)	2	The information needed to generate the financial and program analysis report is readily available, centrally located, up-to-date and easy to verify.	3
<b>Effort to Perform</b>	Efficiency is increased as the process is standardized and the information gathered is more complete and accurate. (No change from the current view)	2	The generation of the financial and program analysis report is efficient as the data is more readily available.	3
<b>Cost Effectiveness</b>	Standardization reduces the cost to generate the financial and program analysis report and the quality of the process increases. (No change from the current view)	2	The generation of the financial and program analysis report is cost effective and the results are accurate, dependable, traceable, and easy to maintain.	3
<b>Accuracy of Process</b>	Standardized methodologies and data produce a more accurate and useable financial and program analysis report. Accuracy improves over Level 1. (No change from the current view)	2	Use of MITA standard interfaces further improves the usefulness of report results and improves accuracy over Level 2.	3
<b>Value to Stakeholders</b>	Standardization has provided more clear and useful information for stakeholders. (No change from the current view)	2	Automation and use of MITA standard interfaces improves Stakeholders’ confidence in financial reports, resulting in improved satisfaction over Level 2.	3

## 11.17 Maintain Benefits/Reference Information

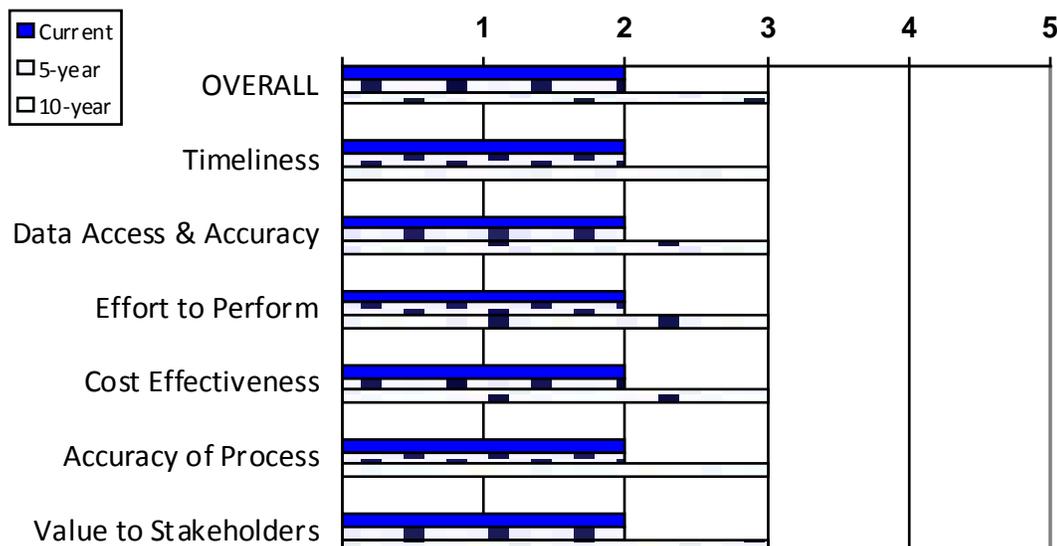
### 11.17.1 MITA Business Process Model

- Program Management: PG6 Maintain Benefits/Reference Information

### 11.17.2 Future Capability Overview

As shown in the figure below, the Maintain Benefits /Reference Information business process will remain at a level 2 over the next 5 years. Within 10 years, the Maintain Benefits/Reference Information business process will reach a level 3 with the process utilizing MITA data definitions and standard interfaces. Maximum flexibility to make changes to reference data based on department decisions will be realized. All qualities for this business process currently are at a level 2.

Figure 60: Current and Future Maturity Levels by Quality: Maintain Benefits/Reference Information



### **11.17.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Maintain Benefits/Reference Information business process:

#### **Strategic Planning Influences**

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to manage the financial stability of the program.<sup>234</sup>
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration.<sup>235</sup>
- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.<sup>236</sup>
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal

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<sup>234</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>235</sup> *ibid*

<sup>236</sup> *ibid*

Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.<sup>237</sup>

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the Department's budgeting and accounting functions.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>238</sup>
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.<sup>239</sup>

## **11.17.4 Expected Characteristics**

### **5-Year View**

The Maintain Benefits/Reference Information business process will remain at the current view capability level 2 for the next 5 years.

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<sup>237</sup> U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

<sup>238</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

<sup>239</sup> Ibid, Slide 6

**This business process is not expected to be at Level 3 within 5 years. Current capabilities for all qualities of the Maintain Benefits-Reference Information are at Level 2.**

The table below summarizes the capabilities for the Maintain Benefits/Reference Information business process for the next 5 years.

### 10-Year View

MITA standardized data improves analysis and research required for maintenance of multiple benefits packages and reference information. This ability supports a capability level 3 within 10 years for the Maintain Benefits/Reference Information business process

Full collaboration with other departments to accept MITA standards to define reference data improves the process.

The table below summarizes the capability improvements for the Maintain Benefits/Reference Information business process that are targeted 5-10 years from now.

**Table 60: Future Maturity Level by MITA Quality: Maintain Benefits/Reference Information**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	The use of automated tools allows more flexibility to adjust to change improves process over Level 2. (No change from the current view)	2	Maximum flexibility to make changes to reference data based on agency decisions.	3
<b>Timeliness</b>	Automation improves timeliness over that at Level 1. (No change from the current view)	2	Use of MITA standard data further improves timeliness beyond Level 2.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Data Access &amp; Accuracy</b>	Due to increased automation, accessibility improves over Level 1. (No change from the current view)	2	Due to adoption of MITA standards, accessibility is improved over Level 2.	3
<b>Effort to Perform</b>	Flexibility increases. Use of national data exchange standards (HIPAA) increases efficiency over Level 1. (No change from the current view)	2	Use of MITA standard interface in addition to State's flexibility in adoption of reference material maximizes efficiency for this process.	3
<b>Cost Effectiveness</b>	Standard Development Organizations provide scheduled updates. Staff is involved in adaptations and extensions of the standards provided. (No change from the current view)	2	Effectiveness is measured by number of staff who can focus on analysis of results of use of reference information.	3
<b>Accuracy of Process</b>	Accuracy improves over Level 1 with use of national HIPAA requirements for data. (No change from the current view)	2	Reference data accuracy further improves over Level 2 with adoption of MITA data definitions and MITA standard interfaces.	3
<b>Value to Stakeholders</b>	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. (No change from the current view)	2	Medicaid enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities.	3

## 11.18 Manage Program Information

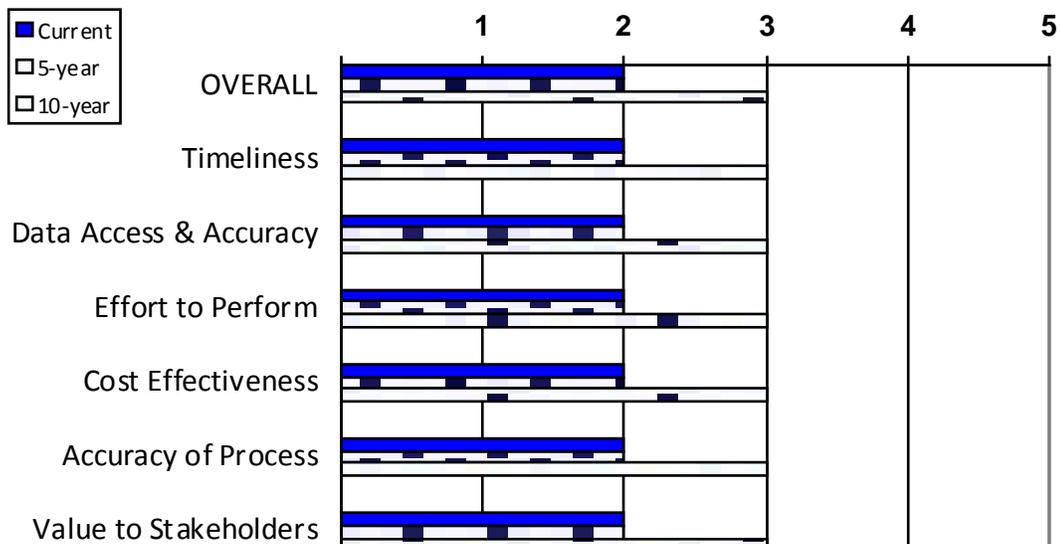
### 11.18.1 MITA Business Process Model

- Program Management: PG6 Manage Program Information

### 11.18.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage Program Information business process remain at a capability level 2 in 5 years. Within 10 years, all aspects of this process will be at a level 3, where the adoption of MITA data models increased standardization of data. Request for information can be sent to other states that also adhere to MITA standards. All qualities for this business process currently are at a level 2.

Figure 61: Current and Future Maturity Levels by Quality: Manage Program Information



### **11.18.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Manage Program Information business process:

#### **Strategic Planning Influences**

- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>240</sup>
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the Medicaid program), which may result in further enhancements to the care planning process.<sup>241</sup>
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information required for the payment of claims.<sup>242</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create

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<sup>240</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>241</sup> *ibid*

<sup>242</sup> Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

mechanisms that support the Department’s goal of rewarding improved plan performance.<sup>243</sup>

- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical “home” (e.g., PCP).

### **Facilitators and Barriers**

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the program management-related components of this system and are critical to the efficient operation of this business process.
- Replacement of the State's Eligibility system, InRhodes. Scope of project to be determined as either an entire replacement for all RI social services or just a new Medical Assistance system specifically for Medicaid.

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<sup>243</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

Implementation of a new, state-of-the-art eligibility system will greatly facilitate increased capability within all member management functions.

- A theme understood by EOHHS is the need for improved case management, including data integration. Enhancing the Community Supports Management (CSM) application or implementation of a new, agency-wide integrated case management system will facilitate the Department's ability to among other things, ensure Medicaid beneficiaries are receiving the right service at the right time and in the correct setting.<sup>244</sup>
- A variety of incentives exist for health plans to submit timely and accurate encounter data. An encounter data component in the health plan capitation calculation provides health plans with an incentive to submit accurate, timely, and a consistent volume of data. HEDIS also provides incentive for health plans to process quality encounter data, including HEDIS awards. The 'default algorithm' is also another means of incentivizing health plans.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.<sup>245</sup>

#### 11.18.4 Expected Characteristics

##### 5-Year View

The Manage Program Information business process will remain at the current view capability level 2 for the next 5 years.

**This business process is not expected to be at Level 3 within 5 years. Current capabilities for all qualities of the Manage Program Information are at Level 2.**

<sup>244</sup> Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 7

<sup>245</sup> Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

The table below summarizes the capabilities for the Manage Program Information business process for the next 5 years.

### 10-Year View

The ability for business users to have direct and dynamic access to centralized and federated data will support a level 3 capability for this business process within 10 years.

The business process will benefit from the adoption of MITA data models that increases standardization of data. Requests for information can be sent to other states that also adhere to MITA standards. The Department collaborates with any other entity that enters into agreements to adhere to MITA interface requirements, security protocols, and privacy rules.

The table below summarizes the capability improvements for the Manage Program Information business process that are targeted 5-10 years from now.

**Table 61: Future Maturity Level by MITA Quality: Manage Program Information**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Some automation has been implemented resulting in business users having the capability of accessing information directly. (No change from the current view)	2	Business users have direct and dynamic access to centralized and federated data.	3
<b>Timeliness</b>	Use of Commercial Off The Shelf (COTS) products and tools dramatically improves the turnaround time to produce program information. (No change from the current view)	2	Use of MITA standards further reduces the time required to produce the desired result.	3
<b>Data Access &amp; Accuracy</b>	The process uses on-line access to data. Use of COTS packages, tools, and HIPAA compliant data improves accessibility. (No change from the current view)	2	Immediate access to standardized data is available further improving accessibility over Level 2.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Effort to Perform</b>	Process efficiency greatly improves through automation and HIPAA data standards. In addition, business areas can manage many of their own inquiries. (No change from the current view)	2	Process efficiency further improves due to use of MITA interface standards which significantly reduces data errors and redundancies.	3
<b>Cost Effectiveness</b>	Cost-effectiveness improves over Level 1 through the use of automation and HIPAA data standards. (No change from the current view)	2	The process maximizes time of tactical and strategic staff to obtain answers critical to planning and policy decisions.	3
<b>Accuracy of Process</b>	Additional automation produces more accurate results than at Level 1. (No change from the current view)	2	Use of MITA interface standards further improves accuracy of results over Level 2.	3
<b>Value to Stakeholders</b>	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. (No change from the current view)	2	Medicaid Enterprise conducts internal and external audits/focus groups which take into consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made.	3

# 12.0 PROVIDER MANAGEMENT

## 12.1 Enroll RI Medicaid Provider

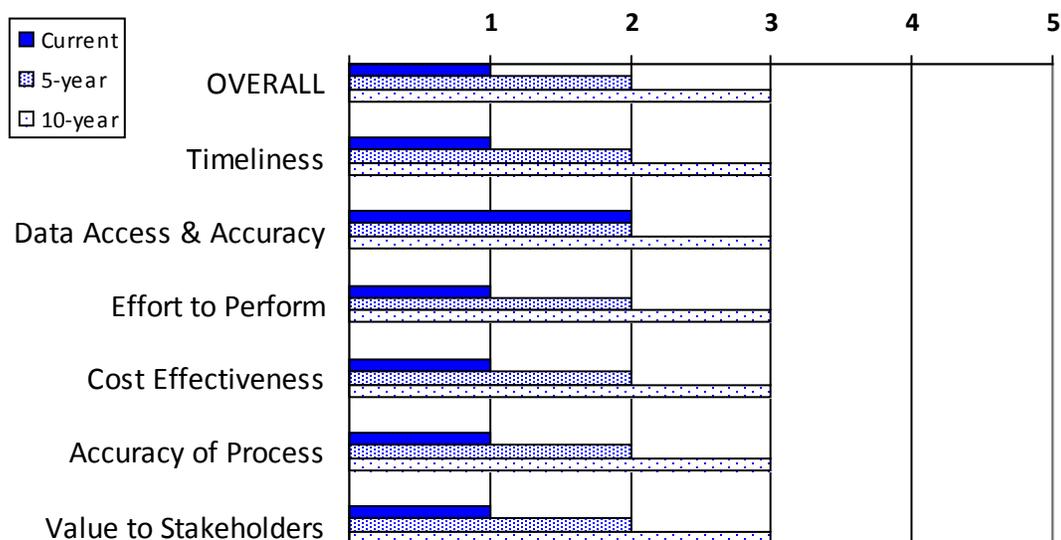
### 12.1.1 MITA Business Process Model

- Provider Management: PM Enroll Provider

### 12.1.2 Future Capability Overview

As shown in the figure below, all aspects of the Enroll RI Medicaid Provider business process will be at a capability level 2 in 5 years, with timelier processing, introduction of web portals, and some automation of business rules. Within 10 years, all aspects of this process will be at a level 3, with flexible business rules and harmonization of the process across all programs with providers who treat RI Medicaid patients. Agencies will have electronic application submission, automated verifications, and greater use of cultural and linguistic indicators. Most qualities for this business process currently are at a level 1.

**Figure 62: Current and Future Maturity Levels by Quality: Enroll RI Medicaid Provider**



### **12.1.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Enroll RI Medicaid Provider business process:

#### **Strategic Planning Influences**

- Ensuring that RI Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>246</sup>
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the RI Medicaid program), which may result in further enhancements to the care planning process.<sup>247</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).<sup>248</sup>

#### **Facilitators and Barriers**

- The new provider enrollment process will utilize an online RI Provider Enrollment Portal application. The Provider Portal will streamline

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<sup>246</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>247</sup> *ibid*

<sup>248</sup> *ibid*

enrollment data collection and agreements through electronic submission, including the submission of an electronic signature and attestation.

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the RI Medicaid program, which could necessitate additional provider enrollment to address access to care for recipients.
- A theme understood by EOHHS is the need for improved case management, including data integration. Enhancing the Community Supports Management (CSM) application or implementation of a new, agency-wide integrated case management system will facilitate the Department's ability to among other things, ensure RI Medicaid beneficiaries are receiving the right service at the right time and in the correct setting.<sup>249</sup>

### **12.1.4 Expected Characteristics**

#### **5-Year View**

With immediate processing using web portals and some automation of business rules, the Enroll RI Medicaid Provider business process will be at a capability level 2 within 5 years.

Increased use of automated business rules to process web-based applications will improve the timeliness, accuracy, and cost effectiveness of this business process. Providers will be able to enroll online and check status of application while in process.

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<sup>249</sup> Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 7

**This Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for most qualities of the Enroll RI Medicaid Provider are at Level 1.**

The table below summarizes the capability improvements for the Enroll RI Medicaid Provider business process that are targeted over the next 5 years.

### **10-Year View**

Standardization of the process, as well as electronic application submission, automated verifications, and use of cultural and linguistic indicators will support a level 3 capability for this business process within 10 years.

During this period of time, the application process for all RI Medicaid providers will be standardized using provider-specific electronic applications implementation, with few exceptions requiring manual steps. The different business areas will share systems, processes or interfaces to process enrollment information. Verifications will be automated using standard interfaces, and business rules will improve consistency in enrollment requirements.

The table below summarizes the capability improvements for the Enroll RI Medicaid Provider business process that are targeted 5-10 years from now.

**Table 62: Future Maturity Level by MITA Quality: Enroll RI Medicaid Provider**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Process can be expedited using web portals and some automated business rules, although some manual steps may continue.	2	Process will be standardized and will include electronic applications, automated verifications, and cultural and linguistic indicators.	3
<b>Timeliness</b>	Process timeliness continues to improve	2	Turnaround time on application decision can be immediate.	3
<b>Data Access &amp; Accuracy</b>	Application data will be standardized within each agency. (No Change from the Current View).	2	Application data interfaces will be standardized nationally using standards.	3
<b>Effort to Perform</b>	Enrollment processes continue to be handled by siloed programs. Providers can submit on paper and electronically via a portal.	2	Most applications will be submitted electronically. Electronic applications will adhere to standard interface requirements.	3
<b>Cost Effectiveness</b>	Process requires less effort which allows staff to focus on other activities.	2	Shared processes and inter-agency collaboration will contribute to streamlining the process.	3
<b>Accuracy of Process</b>	Automation of some business rules improves accuracy of validation and verification.	2	All verifications will be automated and conducted via standardized interfaces.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Value to Stakeholders</b>	More members will be assigned to PCPs to coordinate their care.	2	Cultural and linguistic indicators will improve provider selection.	3

## 12.2 Disenroll RI Medicaid Provider

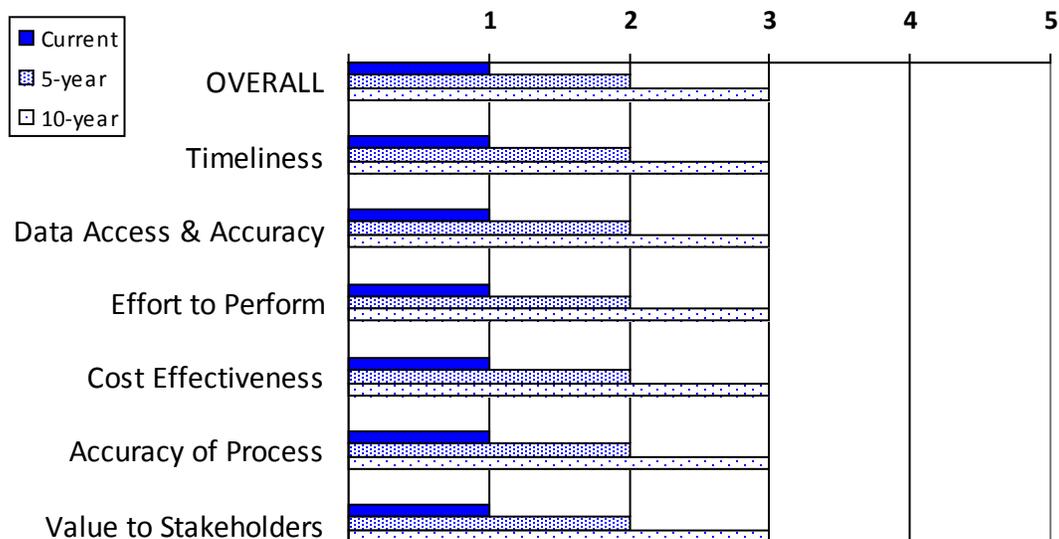
### 12.2.1 MITA Business Process Model

- Provider Management: PM Disenroll Provider overview

### 12.2.2 Future Capability Overview

As shown in the figure below, all aspects of the Disenroll RI Medicaid Provider business process will be at a capability level 2 in 5 years, with automated responses to requests for disenrollment. Within 10 years, all aspects of this process will be at a level 3, with use of information sharing standards and the various agencies that serve RI Medicaid collaborating to exchange provider information. All qualities for this business process currently are at a level 1.

Figure 63: Current and Future Maturity Levels by Quality: Disenroll RI Medicaid Provider



### **12.2.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Disenroll RI Medicaid Provider business process:

#### **Strategic Planning Influences**

- Ensuring that RI Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>250</sup>
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the RI Medicaid program), which may result in further enhancements to the care planning process.<sup>251</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).<sup>252</sup>

#### **Facilitators and Barriers**

- The new provider enrollment process will utilize an online RI Provider Enrollment Portal application. The Provider Portal will streamline

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<sup>250</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>251</sup> *ibid*

<sup>252</sup> *ibid*

enrollment data collection and agreements through electronic submission, including the submission of an electronic signature and attestation.

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the RI Medicaid program, which could necessitate additional provider enrollment to address access to care for recipients.

#### 12.2.4 Expected Characteristics

##### 5-Year View

With automated responses to requests for disenrollment and access via a web portal, the Disenroll RI Medicaid Provider business process will be at a capability level 2 within 5 years.

Within this timeframe, requests to disenroll providers can be responded to immediately using automated messages. The business process will be faster and more accurate with use of standardized data.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for all qualities of the Disenroll RI Medicaid Provider are at Level 1.**

The table below summarizes the capability improvements for the Disenroll RI Medicaid Provider business process that are targeted over the next 5 years.

### 10-Year View

Use of information sharing standards and the various agencies that serve RI Medicaid collaborating to exchange provider information will support a level 3 capability for this business process within 10 years.

Responses will be immediate using standardized data and interfaces across agencies sharing provider data. Standardization of interfaces will provide common messaging for accessing provider information and requesting disenrollment. Messages will be sent immediately back to the requester based on automated business rules.

The table below summarizes the capability improvements for the Disenroll RI Medicaid Provider business process that are targeted 5-10 years from now.

**Table 63: Future Maturity Level by MITA Quality: Disenroll RI Medicaid Provider**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	<b>Requests to disenroll are automated and allow for accurate and immediate response.</b>	<b>2</b>	<b>The process will utilize standards for information sharing between agencies.</b>	<b>3</b>
<b>Timeliness</b>	Requests to disenroll provider will be automated via AVRS, Web portal, or EDI within each agency using agency standards for messages.	2	Responses will be immediate.	3
<b>Data Access &amp; Accuracy</b>	Access via Web portal and EDI channels.	2	Data inquiry messages will use standard interfaces, improving accuracy.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Effort to Perform</b>	With more automation staff can be refocused to other functions.	2	Common data sets and interfaces for agencies who share providers.	3
<b>Cost Effectiveness</b>	Number of disenrollment requests per day can increase significantly.	2	Use of standard interfaces streamlines the disenrollment process.	3
<b>Accuracy of Process</b>	Automation will improve accuracy of responses.	2	Standard interfaces produce consistent responses to requests.	3
<b>Value to Stakeholders</b>	Requesters will receive immediate responses.	2	Requesters will have common access collaborating agencies to obtain information on a provider.	3

## 12.3 Inquire RI Medicaid Provider

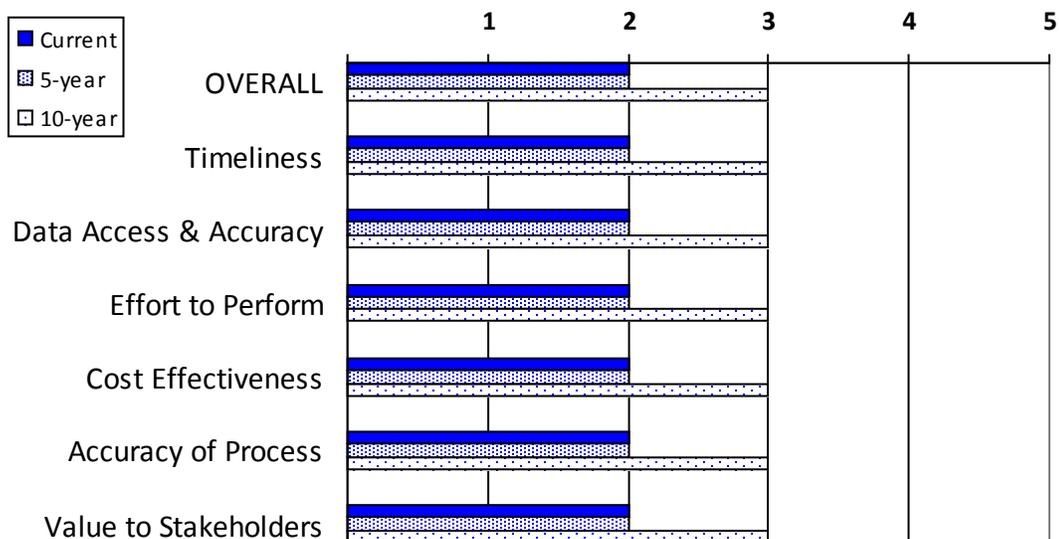
### 12.3.1 MITA Business process model

- Provider Management: PM Inquire Provider Information

### 12.3.2 Future Capability Overview

As shown in the figure below, all aspects of the Inquire RI Medicaid Provider Information business process will remain at a capability level 2, as there are no initiatives that will significantly impact the maturity of this process in 5 years. Within 10 years, all aspects of this process will be at a level 3, with use of federated Provider Registries, introduction of clinical data, and an increased focus on provider performance. All qualities for this business process currently are at a level 2.

**Figure 64: Current and Future Maturity Levels by Quality: Inquire RI Medicaid Provider**



### **12.3.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 10-year capabilities for the Inquire RI Medicaid Provider business process:

#### **Strategic Planning Influences**

- Ensuring that RI Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>253</sup>
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the RI Medicaid program), which may result in further enhancements to the care planning process.<sup>254</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).<sup>255</sup>

#### **Facilitators and Barriers**

- The new provider enrollment process will utilize an online RI Provider Enrollment Portal application. The Provider Portal will streamline

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<sup>253</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>254</sup> *ibid*

<sup>255</sup> *ibid*

enrollment data collection and agreements through electronic submission, including the submission of an electronic signature and attestation.

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the RI Medicaid program, which could necessitate additional provider enrollment to address access to care for recipients.

### 12.3.4 Expected Characteristics

#### 5-Year View

The Inquire RI Medicaid Provider business process will remain at a capability level 2 within 5 years.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for all qualities of the Inquire RI Medicaid Provider are currently at Level 2. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.**

The table below summarizes the capabilities for the Inquire RI Medicaid Provider business process for the next 5 years.

#### 10-Year View

Use of real-time electronic information to exchange data between agency partners and almost full automation will support a level 3 capability for this business process within 10 years.

Responses will be immediate using standardized data and interfaces across agencies sharing provider data. Standardization of interfaces will provide a universal framework requesting and accessing provider information. Messages will be sent immediately back to the requester based on automated business rules.

The table below summarizes the capability improvements for the Inquire RI Medicaid Provider Information business process that are targeted 5-10 years from now.

**Table 64: Future Maturity Level by MITA Quality: Inquire RI Medicaid Provider**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Inquiries are automated and allow for accurate and immediate response. (No change from the Current View)	2	Data can be exchanged with other agencies using standard interfaces. Response time will be immediate.	3
<b>Timeliness</b>	Requests for provider information will be automated via AVRS, Web portal, EDI within an agency using agency standards for messages. (No change from the Current View)	2	Responses will be immediate. Information can be shared among authorized entities within the state.	3
<b>Data Access &amp; Accuracy</b>	Access via Web portal and EDI channels. (No change from the Current View)	2	Collaborating agencies using the standard interfaces can exchange data on registered providers who access multiple agencies or programs	3
<b>Effort to Perform</b>	With more automation staff can be refocused to other functions. (No change from the Current View)	2	Provider information will be continuously refreshed.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Cost Effectiveness</b>	Number of responses per day will increase significantly. (No change from the Current View)	2	Use of standard interfaces will streamline the inquiry process.	3
<b>Accuracy of Process</b>	Automation will improve accuracy of responses. (No change from the Current View)	2	Standard interfaces produce consistent responses to inquiries.	3
<b>Value to Stakeholders</b>	Requesters will receive immediate responses. (No change from the Current View)	2	Requesters will access data from collaborating agencies to obtain information on a provider.	3

## 12.4 Manage RI Medicaid Provider Information

### 12.4.1 MITA Business Process Model

- Provider Management: PM Manage Provider Information

### 12.4.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid Provider Information business process will be at a capability level 2 in 5 years, with web access and automatic processing of provider information updates. Within 10 years, all aspects of this process will be at a level 3, with data exchange partners receiving updated provider information instantly from the Provider Registry. All qualities for this business process currently are at a level 1.

Figure 65: Current and Future Maturity Levels by Quality: Manage RI Medicaid Provider Information



### **12.4.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence the priorities related to reaching the 5- and 10-year capabilities for the Manage RI Medicaid Provider Information business process:

#### **Strategic Planning Influences**

- Ensuring that RI Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>256</sup>
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the RI Medicaid program), which may result in further enhancements to the care planning process.<sup>257</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).<sup>258</sup>

#### **Facilitators and Barriers**

- The new provider enrollment process will utilize an online RI Provider Enrollment Portal application. The Provider Portal will streamline

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<sup>256</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>257</sup> *ibid*

<sup>258</sup> *ibid*

enrollment data collection and agreements through electronic submission, including the submission of an electronic signature and attestation.

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the RI Medicaid program, which could necessitate additional provider enrollment to address access to care for recipients.

#### 12.4.4 Expected Characteristics

##### 5-Year View

With automatic processing of provider information updates and instant availability, the Manage RI Medicaid Provider Information business process will be at a capability level 2 within 5 years.

Automation will improve accuracy and allow staff to focus on other provider management functions. Changes will be immediately available to users and business processes that need to use provider information. Siloed programs will continue to manage their own provider information.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years.**

**Current capabilities for all qualities of this business process are at Level 1.**

**Significant improvements to this process are not expected until after enhancements to the MMIS, which are targeted for the latter part of the 5-year view.**

The table below summarizes the capability improvements for the Manage RI Medicaid Provider Information business process that are targeted over the next 5 years.

### 10-Year View

Instant notification from the Provider Registry to data exchange partners regarding updated provider information will support a level 3 capability for this business process within 10 years.

Updates to provider information can be immediately processed and alert messages will be sent to data sharing partners. Provider information for most RI Medicaid Providers will be available in a Provider Registry that can be accessed by any, authorized user. The NPI will be the ID of record for all RI Medicaid Providers (excluding atypical providers).

The table below summarizes the capability improvements for the Manage RI Medicaid Provider Information business process that are targeted 5-10 years from now.

**Table 65: Future Maturity Level by MITA Quality: Manage RI Medicaid Provider Information**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Provider updates will be automatically processed and changes will be available immediately.	2	Data exchange partners will receive updated provider information instantly from Provider Registry.	3
<b>Timeliness</b>	Provider updates will be automated with date stamp and audit trail.	2	Data exchange partners will receive update information instantly.	3
<b>Data Access &amp; Accuracy</b>	Changes will be immediately available to users and business processes that need to use this information.	2	Provider records will be stored in either a single Provider Registry or federated Provider Registries that can be accessed by all users of provider data.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Effort to Perform</b>	Updates will be automatically processed.	2	Updates will be distributed to data sharing partners. One stop shop for entities who share providers.	3
<b>Cost Effectiveness</b>	Automation will allow staff to be refocused on other functions.	2	Distributed updates of changes to provider registry will refocus staff.	3
<b>Accuracy of Process</b>	Automation will improve accuracy of validation and verification of database updates.	2	NPI will be the ID of record and will standardize ID and taxonomy updates.	3
<b>Value to Stakeholders</b>	Automated maintenance of provider information ensures that timely, accurate data are available to support member assignment.	2	Members can view provider profiles and locations; make informed choices.	3

## 12.5 Manage RI Medicaid Provider Communication

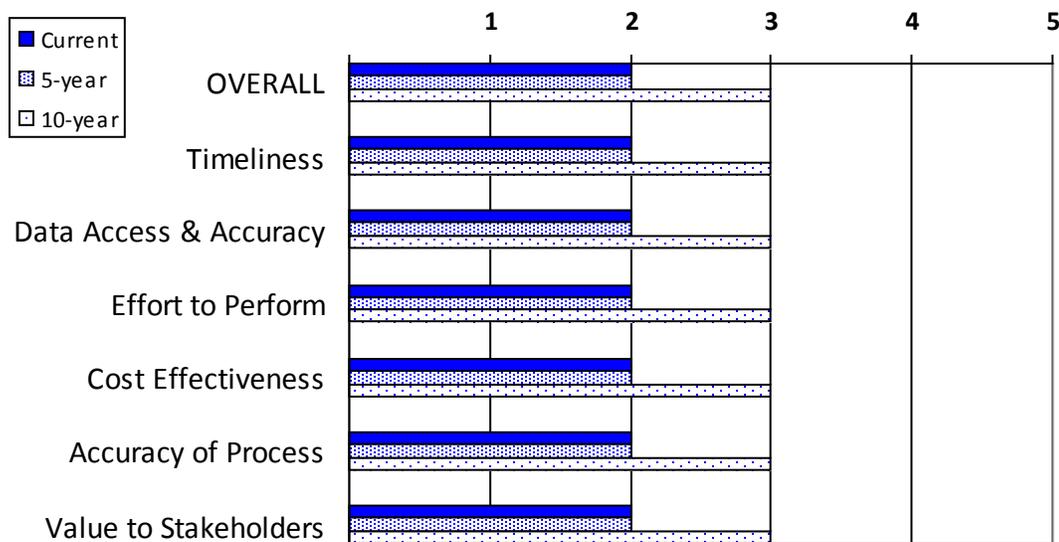
### 12.5.1 MITA Business Process Model

- Provider Management: PM Manage Provider Communication

### 12.5.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid Provider Communication business process will remain at a capability level 2 in 5 years. Within 10 years, all aspects of this process will be at a level 3, with use of a Provider registry that will provide immediate inquiry and response via standard interfaces. All qualities for this business process currently are at a level 2.

**Figure 66: Current and Future Maturity Levels by Quality: Manage RI Medicaid Provider Communication**



### **12.5.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence the priorities related to reaching the 10-year capabilities for the Manage RI Medicaid Provider Communication business process:

#### **Strategic Planning Influences**

- Ensuring that RI Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>259</sup>
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the RI Medicaid program), which may result in further enhancements to the care planning process.<sup>260</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).<sup>261</sup>

#### **Facilitators and Barriers**

- The new provider enrollment process will utilize an online RI Provider Enrollment Portal application. The Provider Portal will streamline

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<sup>259</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>260</sup> *ibid*

<sup>261</sup> *ibid*

enrollment data collection and agreements through electronic submission, including the submission of an electronic signature and attestation.

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the RI Medicaid program, which could necessitate additional provider enrollment to address access to care for recipients.

#### 12.5.4 Expected Characteristics

##### 5-Year View

The Manage RI Medicaid Provider Communication business process will remain at a capability level 2 within 5 years.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years.**

**Current capabilities for all qualities of this business process are at Level 2.**

**Significant improvements to this process are not expected until after enhancements to the MMIS, which is targeted for the latter half of the 5-year view.**

The table below summarizes the capability levels for the Manage RI Medicaid Provider Communication business process for the next 5 years.

##### 10-Year View

Use of a Provider registry that will provide immediate inquiry and response via standard interfaces will support a level 3 capability for this business process within 10 years.

A Provider registry will allow providers to inquire and obtain immediate response using request and response messaging. Standard interfaces will allow a one-stop show for provider inquiries regarding any part of the RI Medicaid program.

The table below summarizes the capability improvements for the Manage RI Medicaid Provider Communication business process that are targeted 5-10 years from now.

**Table 66: Future Maturity Level by MITA Quality: Manage RI Medicaid Provider Communication**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Responses to routine provider requests will be automated. <b>No Change from the Current View</b>	2	<b>Provider registry will provide immediate inquiry and response using standard interfaces.</b>	3
<b>Timeliness</b>	Provider requests and responses will be automated via Web, AVRS, EDI with date stamp and audit trail. (No Change from the Current View)	2	Inquiries and responses using standard interfaces will be immediate.	3
<b>Data Access &amp; Accuracy</b>	Automated responses will increase accuracy. Access will be via Web portal and EDI channels. (No Change from the Current View)	2	Provider information will be accessed via either a single Provider Registry or federated Provider Registries.	3
<b>Effort to Perform</b>	Responses to routine provider requests will be automated. (No change from the Current View)	2	Collaboration among agencies will achieve a one-stop shop for provider inquiries, e.g., mental health provider requests enrollment status from Medicaid, Mental Health Department, MCO.	3
<b>Cost Effectiveness</b>	Automation will allow staff to be refocused on other functions. (No change from the Current View)	3	Use of standards and collaboration among agencies will increase effectiveness.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Accuracy of Process</b>	Automation will improve accuracy of responses. (No change from the Current View)	2	Standard interfaces will specify requests and response messages and are used by collaborating agencies in the state.	3
<b>Value to Stakeholders</b>	Routine communications will be created to meet the needs of all providers. (No change from the Current View)	2	Providers will have a one stop shop to access collaborating agencies to obtain information.	3

## 12.6 Manage RI Medicaid Provider Grievance and Appeal

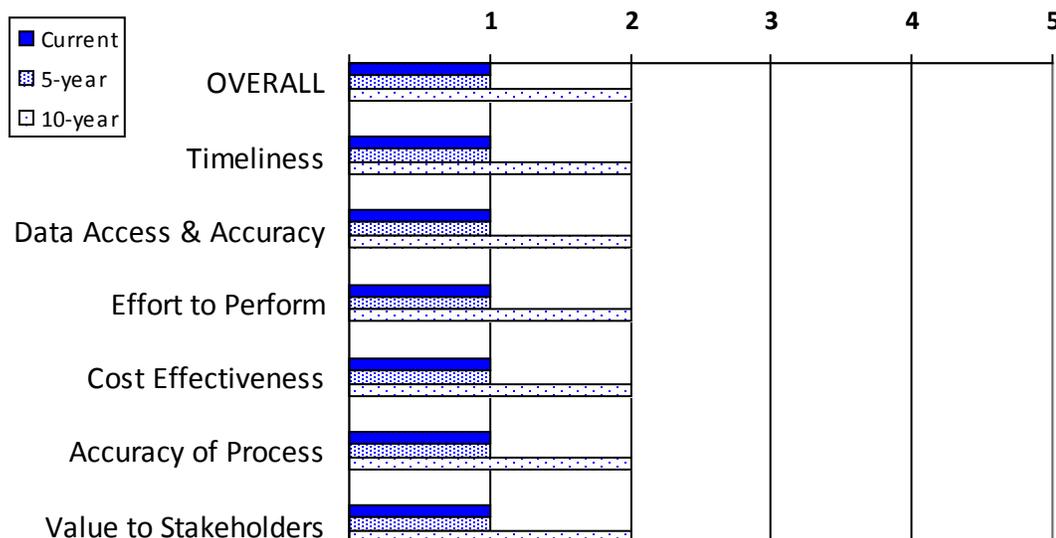
### 12.6.1 MITA Business Process Model

- Provider Management: PM Manage Provider Grievance and Appeal

### 12.6.2 Future Capability Overview

As shown in the figure below, all aspects of the Manage RI Medicaid Provider Grievance and Appeal business process will remain at a capability level 1 in 5 years. There are no initiatives that will significantly impact the capabilities of this business process within 5 years. Within 10 years, all aspects of this process will be at a level 2, with the introduction of automation. All qualities for this business process currently are at a level 1.

**Figure 67: Current and Future Maturity Levels by Quality: Manage RI Medicaid Provider Grievance and Appeal**



### **12.6.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 10-year capabilities for the Manage RI Medicaid Provider Grievance and Appeal business process:

#### **Strategic Planning Influences**

- Ensuring that RI Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>262</sup>
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the RI Medicaid program), which may result in further enhancements to the care planning process.<sup>263</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).<sup>264</sup>

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<sup>262</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>263</sup> *ibid*

<sup>264</sup> *ibid*

## Facilitators and Barriers

- The new provider enrollment process will utilize an online RI Provider Enrollment Portal application. The Provider Portal will streamline enrollment data collection and agreements through electronic submission, including the submission of an electronic signature and attestation.
- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the RI Medicaid program, which could necessitate additional provider enrollment to address access to care for recipients.

### 12.6.4 Expected Characteristics

#### 5-Year View

The Manage RI Medicaid Provider Grievance and Appeal business process will remain at a capability level 1 within 5 years.

**This RI Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for all qualities of the Manage RI Medicaid Provider Grievance and Appeal business process are currently at Level 1. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years.**

The table below summarizes the capability improvements for the Manage RI Medicaid Provider Grievance and Appeal business process that are targeted over the next 5 years.

### 10-Year View

With web-based access to case files and automation of some business process steps, the Manage RI Medicaid Provider Grievance and Appeal business process will be at a capability level 2 within 10 years.

Case files will be completely electronic with paper files/documents that are scanned and linked to the case. The case files will be accessed via a web-portal and verification of case file information will be responded to immediately. Agency standards for case inquiries will be introduced for sharing with other entities involved in the case who have a business need to access the information.

**This RI Medicaid business process is not expected to be at Level 3 within 10 years. Current capabilities for all qualities of the Manage RI Medicaid Provider Grievance and Appeal business process are currently at Level 1.**

The table below summarizes the capability improvements for the Manage RI Medicaid Provider Grievance and Appeal business process that are targeted 5-10 years from now.

**Table 67: Future Maturity Level by MITA Quality: Manage RI Medicaid Provider Grievance and Appeal**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	This is an all-manual process. <b>No change from the Current View.</b>	1	<b>Case file will be accessed via web portal. Automation of some steps will improve response time and cost effectiveness.</b>	2
<b>Timeliness</b>	This is an all-manual process. (No change from Current View)	1	Documents will be scanned and the case file will be automated and shared among case workers.	2

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Data Access &amp; Accuracy</b>	Information is researched manually. (No change from Current View)	1	Access will be via Web portal and EDI channels.	2
<b>Effort to Perform</b>	Staff research and maintain manually. (No change from Current View)	1	Responses to requests to verify provider case information will be automated.	2
<b>Cost Effectiveness</b>	Process is labor-intensive. Results take several months. (No change from Current View)	1	Automation of some research steps will allow staff to focus on other business functions.	2
<b>Accuracy of Process</b>	Terms of the settlement or results of the hearing are manually documented according to the administrative rules of the state. (No change from Current View)	1	Automation will be introduced into the case management process.	2
<b>Value to Stakeholders</b>	Business process complies with agency and state requirements for a fair hearing and disposition. (No change from Current View)	1	The provider and the agency will benefit from introduction of automation to speed up the case resolution.	2

## 12.7 Perform Provider Enrollment Certification

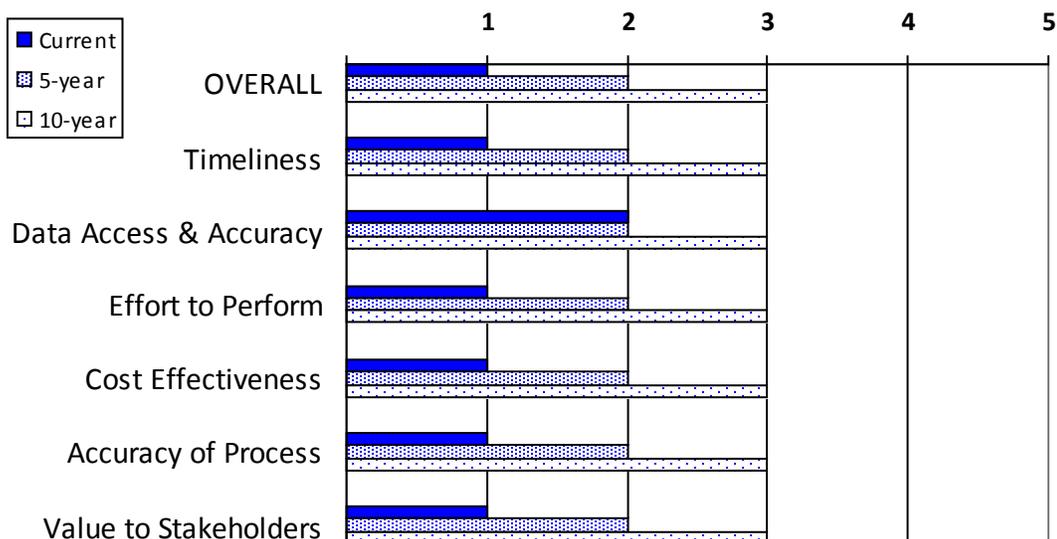
### 12.7.1 MITA Business Process Model

- State Specific: Perform Provider Enrollment Certification

### 12.7.2 Future Capability Overview

As shown in the figure below, all aspects of the Perform Provider Enrollment Certification business process will be at a capability level 2 in 5 years, with timelier processing, introduction of web portals, and some automation of business rules. Within 10 years, all aspects of this process will be at a level 3, with flexible business rules and harmonization of the process across all programs with providers who treat RI Medicaid patients. Agencies will have electronic application submission, automated verifications, and greater use of cultural and linguistic indicators. Most qualities for this business process currently are at a level 1.

Figure 68: Current and Future Maturity Levels by Quality: Perform Provider Enrollment Certification



### **12.7.3 Influences, Barriers and Facilitators**

Among the many activities impacting the Department, the following developments are expected to influence significantly the priorities related to reaching the 5- and 10-year capabilities for the Perform Provider Enrollment Certification business process:

#### **Strategic Planning Influences**

- Ensuring that RI Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.<sup>265</sup>
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the RI Medicaid program), which may result in further enhancements to the care planning process.<sup>266</sup>
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in Rite Share/Rite Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).<sup>267</sup>

#### **Facilitators and Barriers**

- The new provider enrollment process will utilize an online RI Provider Enrollment Portal application. The Provider Portal will streamline

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<sup>265</sup> Executive Office of Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

<sup>266</sup> *ibid*

<sup>267</sup> *ibid*

enrollment data collection and agreements through electronic submission, including the submission of an electronic signature and attestation.

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the RI Medicaid program, which could necessitate additional provider enrollment to address access to care for recipients.
- A theme understood by EOHHS is the need for improved case management, including data integration. Enhancing the Community Supports Management (CSM) application or implementation of a new, agency-wide integrated case management system will facilitate the Department's ability to among other things, ensure RI Medicaid beneficiaries are receiving the right service at the right time and in the correct setting.<sup>268</sup>

## **12.7.4 Expected Characteristics**

### **5-Year View**

With immediate processing using web portals and some automation of business rules, the Perform Provider Enrollment Certification business process will be at a capability level 2 within 5 years.

Increased use of automated business rules to process web-based applications will improve the timeliness, accuracy, and cost effectiveness of this business process. Providers can enroll online or on paper using applications standardized.

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<sup>268</sup> Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 7

**This Medicaid business process is not expected to be at Level 3 within 5 years. Current capabilities for most qualities of the Perform Provider Enrollment Certification are at Level 1.**

The table below summarizes the capability improvements for the Perform Provider Enrollment Certification business process that are targeted over the next 5 years.

### **10-Year View**

Standardization of the process, as well as electronic application submission, automated verifications, and use of cultural and linguistic indicators will support a level 3 capability for this business process within 10 years.

During this period of time, the application process for all RI Medicaid providers will be standardized using provider-specific electronic applications implementation, with few exceptions requiring manual steps. The different business areas will share systems, processes or interfaces to process enrollment information. Verifications will be automated using standard interfaces, and business rules will improve consistency in enrollment requirements.

The table below summarizes the capability improvements for the Perform Provider Enrollment Certification business process that are targeted 5-10 years from now.

**Table 68: Future Maturity Level by MITA Quality: Perform Provider Enrollment Certification**

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>OVERALL</b>	Process can be expedited using web portals and some automated business rules, although some manual steps may continue.	2	Process will be standardized and will include electronic applications, automated verifications, and cultural and linguistic indicators.	3
<b>Timeliness</b>	Process timeliness continues to improve	2	Turnaround time on application decision can be immediate.	3
<b>Data Access &amp; Accuracy</b>	Application data will be standardized within each agency. (No Change from the Current View).	2	Application data interfaces will be standardized nationally using standards.	3
<b>Effort to Perform</b>	Enrollment processes continue to be handled by siloed programs. Providers can submit on paper and electronically via a portal.	2	Most applications will be submitted electronically. Electronic applications will adhere to standard interface requirements.	3
<b>Cost Effectiveness</b>	Process requires less effort which allows staff to focus on other activities.	2	Shared processes and inter-agency collaboration will contribute to streamlining the process.	3
<b>Accuracy of Process</b>	Automation of some business rules improves accuracy of validation and verification.	2	All verifications will be automated and conducted via standardized interfaces.	3

MITA Quality	5-Year View & Level		10-Year View & Level	
<b>Value to Stakeholders</b>	More members will be assigned to PCPs to coordinate their care.	2	Cultural and linguistic indicators will improve provider selection.	3