

MITA Business Process Model

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Business Relationship Management

BR Establish Business Relationship

Tier 2: Establish Business Relationship		
Item	Details	Links
Description	The Establish Business Relationship business process encompasses activities undertaken by the State Medicaid agency to enter into business partner relationships with other stakeholders. These include Memoranda of Understanding (MOUs) with other agencies, electronic data interchange agreements with providers, managed care organizations, and others, and CMS, other Federal agencies, and Regional Health Information Organizations (RHIOs).	Business Process Model location: Tier 1: Business Relationship Management
Trigger Event	Receive data content of agreement submitted by other party	Links to other processes: Receive Agreement Document from Other Party
Result	Produce data content for response to other party	Links to other processes: Send Response to Other Party
Business Process Steps	<ol style="list-style-type: none"> 1. Receive data content of agreement with other party 2. Validate information submitted 3. Verify authentication protocol 4. Verify security protocol 5. Verify privacy requirements 6. Verify data exchange requirements 7. Verify business rules 	Each State will specify its data requirements and rules for each step
Shared Data	<ol style="list-style-type: none"> 1. Standard agreement template 2. Business rules for type of agreement 3. Data from previous agreement for same party 4. Comparable information on other agreements 	
Predecessor	Receive Agreement Document	
Successor	Send Response to Other Party	
Constraints		
Failures	Contents of agreement submitted from other party are incomplete, inaccurate.	Result messages
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete business process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less 	

BR Manage Business Relationship

Tier 2: Manage Business Relationship		
Item	Details	Links
Description	The Manage Business Relationship business process maintains the agreement between the State Medicaid agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards.	Business Process Model location: Tier 1: Business Relationship Management
Trigger Event	Receive agreement updates and new data	Links to other processes: Establish Business Relationship
Result	Produce changes to agreement	Links to other processes: Update Agreement
Business Process Steps	<ol style="list-style-type: none"> 1. Receive agreement updates and new data 2. Validate update and new data 3. Prepare update and new data 	Each State will specify its data requirements and rules for each step
Shared Data	<ol style="list-style-type: none"> 1. Standard agreement template 2. Business rules for type of agreement 3. Data from previous agreement for same party 	
Predecessor	Establish Business Relationship	
Successor	Update Agreement	
Constraints	Updates cover the gamut of all required fields in the agreement and depend on the type of agreement and business rules associated with the agreement.	
Failures	<ol style="list-style-type: none"> 1. Update or new data does not comply with standards 2. Update or new data does not comply with business rules 	Result messages
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete business process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less 	

Case Management

CM Manage Case

Tier 2: Manage Case		
Item	Details	Links
Description	<p>The Manage Case business process describes the means by which a care manager oversees service delivery for individual clients who have been identified through the Establish Case business process.</p> <p>The assigned care manager for a client's case authorize services, monitors and updates treatment plans, communicates with providers and patients, updates care management records, and prepares for discharge from care management. Performance measures on case outcomes may be captured.</p> <p>The MITA Business Process Model for this function is incomplete. This version has been created for Rhode Island.</p>	
Trigger Event	New case opened via the Establish Case business process	
Result	<ol style="list-style-type: none"> 1. Client is discharged from care management 2. Performance metrics are captured and reported 	
Business Process Steps	<ol style="list-style-type: none"> 1. Review treatment plan 2. Monitor treatment plan 3. Update treatment plan (e.g., based on progress, expected results, new client information, or complications), including new providers, programs, care setting, services or products as applicable 4. Communicate with provider(s) 5. Communicate with client (or representative) 6. Update case record with progress reports and new information, including client and provider correspondence 7. Close case (if applicable, close case provisionally, and follow-up with the patient for a period of time before formally closing the case) 8. Evaluate case performance/outcomes (if applicable to program) 	
Shared Data	<ol style="list-style-type: none"> 1. Member Registry: Member demographic, benefit package, enrollment financial, disability data. 2. Provider Registry: Provider data, such as type, location, 3. Authorizations 	Operations Management, Member Management, Provider Management
Predecessor	New case opened via the Establish Case business process	
Successor	Program Management processes monitor and evaluate care management trends and impact	Program Management

CM Manage Case

Tier 2: Manage Case		
Item	Details	Links
Constraints	Patients may not be enrolled in other selected programs (e.g., managed care, Medicare, other waivers, other programs with a case management component, etc.). In addition, patients must be under the care of a physician.	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none">1. Caseload per care manager = __ patients2. Patients with adverse events (e.g., infections, re-admissions) = ____%3. Patients requiring emergency medical transportation = ____%	

CM Manage Medicaid Population Health

Tier 2: Manage Medicaid Population Health		
Item	Details	Links
Description	<p>This business process designs and implements strategies to improve general population health by targeting individuals by cultural or diagnostic or other demographic indicators. The input to this process are census, vital statistics, immigration, and other data sources. The outputs are educational materials, communications, and other media.</p> <p>With the exception of the description above, the MITA Business Process Model is incomplete. This version has been created for Rhode Island.</p>	<p>Operations Management, Member Management, Provider Management, Program Management, Contractor Management, Business Relationship Management</p>
Trigger Event	<ul style="list-style-type: none"> ■ Implementation of population health initiatives such as BCCTP and ESPDT ■ Scheduled communications related to current programs ■ Changes to existing plans or benefit packages ■ New program policies and procedures ■ Changes to existing policies and procedures ■ Critical public health risk identified in a specific target population (e.g., obesity) ■ Identification of new and currently served populations in need of services or access ■ New managed care plan initiative(s) ■ Other State or Federal healthcare mandates 	
Result	<p>Health promotion communications, such as mailings brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements; are produced and distributed to targeted populations or individuals.</p>	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Target population is identified and defined by reviewing program performance measures, feedback from advocacy group, input from business partners (e.g., local health authorities) or contractors (e.g., managed care plans), new legislation, committee findings, and policy directives 2. Determine approach (internal and external or both) supporting materials, policy options, success measures 3. Execute plan, supported by applicable Member Management, Provider Management, Program Management, Business Relationship Management processes (e.g., working with target populations in collaboration with community resources, advocacy groups, providers, and other entities that work with the target population) 6. Assess impact of population health intervention 	

CM Manage Medicaid Population Health

Tier 2: Manage Medicaid Population Health		
Item	Details	Links
Shared Data	<ol style="list-style-type: none"> 1. Program Management Performance Measures, e.g., HEDIS or other survey data 2. Services and Benefits Package: Services and provider types covered; program policy 3. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 4. Contractor Registry: Contractor information, health plan information 5. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence 6. Claims history 7. Other external data (e.g., Vital Records) 	
Predecessor	Program Management processes result in need to perform outreach to prospective members	
Successor	Program Management processes monitor and evaluate population trends and impact	
Constraints	Communications and information packages must address the needs of the target population. Materials must be linguistically and culturally appropriate, legally compliant, appropriate to the targeted group, meet financial guidelines (e.g., cost to produce and distribute). Other constraints may be agency priority, availability of resources, and accuracy of targeting Medicaid beneficiaries	
Failures	<ol style="list-style-type: none"> 1. Inability to provide linguistically, culturally, or competency appropriate information 2. Communication barriers such as lack of reliable mail, internet or other media access (e.g., for mobile communities such as migrant workers or the homeless population) 	
Performance Measures	<p>Impact of effort is monitored through applicable Program Management, Contractor Management, Business Relationship Management processes (e.g., review of program claims or enrollment data)</p> <p>Examples of Measures:</p> <ol style="list-style-type: none"> 1. Time to complete process of developing initiative = ___ days 2. Percent under of over budget for initiative = ___% 3. Successful impact rate for targeted individuals = ___% 	

CO1 Award Health Services Contract

Tier 3: Award Health Services Contract		
Item	Details	Links
Description	The Award Health Services Contract business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.	Business Process Model location: Tier 1: Contractor Management Tier 2: Health Services Contracting
Trigger Event	Interaction-Based Trigger Event: Receives contractor proposals	
Result	<ol style="list-style-type: none"> 1. Contractor award status data (e.g., award, deny, need more information) 2. Data to communicate with contractor 3. Data to update Contractor Registry 	Links to other Business Processes: Manage Contractor Information Manage Contractor Communications
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive proposal data 2. Validate completeness and required fields – business logic identifies mandated fields and applies edits for the Type of Contractor. 3. Verify contractor with external entities – business logic sends message to one or more external entities to verify information in the application, e.g., corporate status. 4. Validate contractor network, resources, and other requirements 5. Assign ID 6. Assign rates or other form of payment 7. Negotiate contract: collect additional information required to complete a contract 8. End: Produce result status (award, deny, continue negotiations) 	Links to other (future) Business Processes: Assign Contractor ID Negotiate Contractor Contract Assign Rates Each State will specify its data requirements and rules for each step in the Business Logic flow.
Shared Data	Contractor Master Registry Other per Type of Contractor	
Predecessor	The predecessor business process, Receive Inbound Transaction (i.e., Proposal), authenticates, verifies format, may translate, may scan, logs in request, and produces the enrollment application message which is sent to the Enroll Contractor business process.	Receive Inbound Transaction
Successor	<ol style="list-style-type: none"> 1. Manage Contractor Communications 2. Manage Contractor Information 	Manage Contractor Communications Manage Contractor Information
Constraints	The Contractor application must accommodate the full range of contractor types.	Business logic differences for type

CO1 Award Health Services Contract

Tier 3: Award Health Services Contract		
Item	Details	Links
Failures	A contractor proposal may fail at the following steps: <ol style="list-style-type: none"> 1. Required fields 2. Verification with one or more external entities 3. Verification with internal sources 4. No established rates 5. Cannot complete contract 	Result messages
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process 2. Accuracy of decisions 3. Consistency of decisions and disposition 	

CM1 Award Health Services Contract

Tier 3: Award Health Services Contract		
Contractor Enrollment Variations		
Type	Subtypes	Data
Institutional Contractor	The Institutional Contractor application must accommodate a range of institutional contractor types (e.g., Inpatient, Nursing Home, Day Care), different types of applicants (e.g., the Primary Contractor, Billing Agent, Pay-To Entity), and care settings (e.g., Outpatient, Emergency Room, Assisted Living)	Type of Facility, Bed Size, Taxonomy, Type of Institutional Services, Ownership, Tax Code, DRG or other payment type
Professional Contractor	The Professional Contractor application must accommodate a range of professional contractor types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, Other), different types of applicants (e.g., the Primary Contractor, Billing Agent, Pay-To Entity), and care settings (e.g., solo office practice, group practice, Rural Health Clinic). Enumerate a Group Health Practice separately from the individual physicians associated with it.	Contractor Type, Affiliation, Location
Pharmacy	The Pharmacy application must accommodate a range of types (e.g., major chain with hundreds of stores, community pharmacy), different types of applicants (e.g., the Primary Contractor, Billing Agent, Pay-To Entity), and care settings (e.g., retail store, outpatient facility, nursing home). The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.	Type, ownership, location, unit dose, mail order, DUR compliance

CM1 Award Health Services Contract

Tier 3: Award Health Services Contract		
Contractor Enrollment Variations		
Type	Subtypes	Data
A-Typical	<p>The A-typical contractor application must accommodate a range of types of programs (e.g., Waiver, assistance in the home), different kinds of service contractors (e.g., family care-taker, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the Primary Contractor, Billing Agent, Pay-To Entity), and care settings (e.g., in the home, day care center).</p> <p>The NPI enumeration will not provide ID numbers for A-typical contractors at this time.</p>	Type of service contractor, allowed services, invoicing method

Contractor Management

CO1 Close-out Health Services Contract

Tier 3: Close-out Health Services Contract		
Item	Details	Links
Description	The Close-out Health Care Services Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	Business Process Model location: Tier 1: Contractor Management Tier 2: Health Services Contracting
Trigger Event	Interaction-based Trigger event: Receive instruction to terminate contract	
Result	Close-out of contract	Links to other E2E threads: Update Contractor Registry Notify Contractor
Business Process Steps	Start: Receive instruction to terminate contract Identify all requirements for termination of contract Monitor closure activities End: Officially terminate contract	
Shared Data	Contractor Registry	
Predecessor	Request to terminate contract	
Successor	1. Manage Contractor Communications 2. Manage Contractor Information	Manage Contractor Communications Manage Contractor Information
Constraints	Each state has its requirements for contract termination.	Business logic differences for type
Failures	N/A	Result messages
Performance Measures	Time to complete process Accuracy of decisions Consistency of decisions Error rate	

CO1 Manage Health Services Contract

Tier 3: Manage Health Services Contracting		
Item	Details	Links
Description	<p>The Manage Health Services Contract business process gathers requirements, develops a Request for Proposals, requests and receives approvals for the RFP, and solicits responses.</p> <p>Health care services include: medical care services, pharmacy benefits, dental benefits, mental health benefits, primary care services, and health care services outsourced to health insurance programs.</p>	<p>Business Process Model location: Tier 1: Contractor Management Tier 2: Health Services Contracting</p>
Trigger Event	<p>Temporal Trigger Event: A Scheduled date for reprourement of health care service contact</p> <p>Interaction-based Trigger Event: Request by Executive Management to reprocore</p>	
Result	<ol style="list-style-type: none"> 1. Advance Planning Document 2. Request for Proposal 	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive directive to procure health care services 2. Gather requirements for health care services 3. Determine if Advance Planning Document (APD) is required <ol style="list-style-type: none"> a. Produce APD b. Receive approval for APD 4. Develop Request for Proposal (RFP)for the health care services 5. Receive internal (state) and federal approvals for RFP 6. Advertise RFP 7. End: Issue RFP 	
Shared Data	<p>Previous RFP</p> <p>Operational data stores</p> <p>Strategic IT Plan</p> <p>Enterprise Architecture</p>	
Predecessor	Determine Need for Health Care Contract	
Successor	Award Health Care Contract	
Constraints	Each state decides what types of health care contracts need to be procured. States engage in a wide range of health care contracts. All states are governed by statutes that provide the legal framework for procurements. Each state's statutes are different from all other states.	Business process steps differ from state to state
Failures	<ol style="list-style-type: none"> 1. The reprourement is challenged 	
Performance Measures	<p>Time to complete process</p> <p>Accuracy of decisions</p> <p>Consistency of decisions and disposition</p>	

CO2 Award Administrative Contract

Tier 3: Award Administrative Contract		
Item	Details	Links
Description	<p>The Award Administrative Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses.</p> <p>Administrative services include: fiscal agent, managed care enrollment broker, professional services review, authorization for services, fraud detection, third party recovery, and many other outsourced services.</p>	<p>Business Process Model location: Tier 1: Business Area: Contractor Management Tier 2: Administrative Contracting</p>
Trigger Event	<p>Temporal Trigger Event: A scheduled date for repurchase of administrative service contact</p> <p>Interaction Based Trigger Event: Receipt of an executive decision to repurchase.</p>	
Result	<ol style="list-style-type: none"> 1. Advance Planning Document 2. Request for Proposal 3. Contract 	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive directive to procure administrative services 2. Gather requirements for administrative services 3. Determine if Advance Planning Document (APD) is required <ol style="list-style-type: none"> a. Produce APD b. Receive approval for APD 4. Develop Request for Proposal (RFP) for the administrative services 5. Receive internal (state) and federal approvals for RFP 6. Advertise RFP 7. End: Issue RFP 	
Shared Data	<p>Previous RFP Operational data stores Strategic IT Plan Enterprise Architecture</p>	
Predecessor	Determine Need for Administrative Contract	
Successor	Award Administrative Contract	
Constraints	Each state decides what types of administrative contracts need to be procured. States engage in a wide range of administrative contracts. All states are governed by statutes that provide the legal framework for procurements. Each state's statutes are different from all other states.	Business process steps differ from state to state
Failures	N/A	
Performance Measures	<p>Time to complete process of procuring an Administrative Contract = __ days</p> <p>Accuracy of RFP = ___%</p>	
Rules Differ by Contractor Type		
Type		

CO2 Award Administrative Contract

Tier 3: Award Administrative Contract		
Item	Details	Links
Fiscal Agent		
MCO Enrollment Broker		
Professional Services Review		
SURS Case Review		
Fraud Detection		
Third Party Recovery		
Provider Relations		
Other		

CO2 Close-out Administrative Contract

Tier 1: Close-out Administrative Contract		
Item	Details	Links
Description	The Close-out Administrative Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.	Business Process Model location: Tier 1: Business Area: Contractor Management Tier 2: Administrative Contracting
Trigger Event	Interaction-based Trigger Event: Instruction to terminate contract	
Result	Close-out of contract	Links to other E2E threads: Update Contractor Registry Notify Contractor
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive instruction to terminate contract 2. Identify all requirements for termination of contract 3. Monitor closure activities 4. End: Officially terminate contract 	
Shared Data	Contractor Database	
Predecessor	Request to terminate contract	
Successor	Manage Contractor Communications Manage Contractor Information	E2E threads: Manage Contractor Communications Manage Contractor Information
Constraints	Requirements and business policies for contract termination may differ by state.	Business logic differences for type
Failures	N/A	Result messages
Performance Measures	Time to complete process. Accuracy with which rules are applied Consistency with which rules are applied	

CO2 Manage Administrative Contract

Tier 1: Manage Administrative Contract		
Item	Details	Links
Description	The Monitor Administrative Contract business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.	Business Process Model location: Tier 1: Business Area: Contractor Management Tier 2: Administrative Contracting
Trigger Event	Interaction-based Trigger Event: Receive Administrative Services Contractor data.	
Result	<ol style="list-style-type: none"> 1. Contractor enrollment status data (e.g., enroll, deny, need more information) 2. Data to communicate with contractor 3. Data to update Contractor Registry 	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive contract award data set from the Receive Inbound Transaction process 2. Implement contract 3. Update contract with amendments (if any) 4. End: Monitor terms of the contract throughout its duration 	
Shared Data	Contractor Database	
Predecessor	The predecessor business process, Receive Inbound Transaction (i.e., Enrollment Application), authenticates, verifies format, may translate, may scan, logs in request, and produces the enrollment application message which is sent to the Enroll Contractor business process.	E2E thread: Receive Inbound Transaction
Successor	<ol style="list-style-type: none"> 1. Manage Contractor Communications 2. Manage Contractor Information 	E2E threads: Manage Contractor Communications Manage Contractor Information
Constraints	Business rules and/or policies may differ by state.	
Failures	N/A	Result messages
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process 2. Accuracy of decisions 3. Consistency of decisions and disposition 	

CO3 Inquire Contractor Information

Tier 3: Inquire Contractor Information		
Item	Details	Links
Description	The <i>Inquire Contractor Information</i> business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the <i>Send Outbound Transaction</i> process.	
Trigger Event	Interaction-based Trigger Event: Receipt of contract verification request data set from <i>Receive Inbound Transaction</i> process.	
Result	<ol style="list-style-type: none"> 1. Contract verification response data set routed to <i>Send Outbound Transaction</i> process. Data set may include information such as contract start/end dates, Contractor type and specific specialties. 2. Tracking information regarding the interchange as needed for the <i>Inquire Contractor Information</i> process for measuring performance and business activity monitoring. 	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receipt of Contract verification information data set from <i>Receive Inbound Transaction</i> Process. 2. Determine Request status as initial or duplicate. 3. Verify authorization of the requester to receive requested information. 4. Query Contractor Registry for requested information 5. Process Response 6. Log Response 7. End: Prepare response data set for the <i>Send Outbound Transaction</i> process 	
Shared Data	Contractor Registry	
Predecessor	<i>Receive Inbound Transaction</i> process	
Successor	<i>Send Outbound Transaction</i> process	
Constraints	States determine what information can be shared and who can access requested information.	
Failures	<ol style="list-style-type: none"> 1. Process unable to process the Contractor information verification request. 2. Requester not authorized to receive requested information. 	
Performance Measures	<ol style="list-style-type: none"> 1. Time to verify Contractor information and generate response data set: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Response Accuracy = __% 3. Error rate = __% or less 	

CO3 Manage Contractor Information

Tier 3: Manage Contractor Information		
Item	Details	Links
Description	The Manage Contractor Information business process receives a request for addition, deletion, or change to the Contractor Registry; validates the request, applies the instruction, and tracks the activity.	Business Area: Tier 1: Contractor Management; Tier 2: Contractor Information Management
Trigger Event	Request to add, delete, change contractor data repository information.	
Result	Modified contractor data repository Tracking information	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive request to apply transaction 2. Validate request 3. Apply transaction to contractor data store 4. End: Report on action taken 	
Shared Data	Receive request to update contractor data repository	
Predecessor	Report on action taken	
Successor	Contractor data repository	
Constraints	Data requirements and data structures for the contractor data store differ from state to state.	
Failures	<ol style="list-style-type: none"> 1. Contractor information not found 2. Inability to respond to a request 	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less 	

CO4 Perform Potential Contractor Outreach

Tier 2: Perform Potential Contractor Outreach		
Item	Details	Links
Description	<p>The Perform Potential Contractor Outreach business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures.</p> <p>For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs.</p> <p>For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives.</p> <p>Contractor outreach communications are distributed through various mediums via the Send Outbound Transaction. All contractor outreach communications are produced, distributed, tracked, and archived by the agency according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.</p>	<p>Business Area: Tier 1: Contractor Management; Tier 2: Contractor Support</p>
Trigger Event	<p>State-transition based Trigger Events: Executive Management decision to:</p> <ul style="list-style-type: none"> ■ Fill gaps in health care service coverage ■ Introduce new programs requiring new types of service ■ Changes to existing policies and procedures ■ Critical need in a specific target population ■ Identification of new populations in need of service, e.g., new immigrant communities 	
Result	<p>Outreach communications, such as mailing brochures, web pages, email, radio, billboard, and TV advertisements; are produced and distributed to targeted contractors.</p>	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Contractor population is identified and defined by analyzing data, performance measures, feedback from community, and policy directives 2. Receive requests to make decisions to develop outreach communications 3. Send outreach communications to be distributed through various mediums supported by the Send Outbound Transaction process using various mediums 4. End: Outreach communications production and distribution are tracked and materials archived 	
Shared Data	<ol style="list-style-type: none"> 1. Care Management population health data 2. Program Quality Management quality measure data 3. Benefit Repository 4. Member Registry 5. Contractor Registry 6. Provider Registry 	

CO4 Perform Potential Contractor Outreach

Tier 2: Perform Potential Contractor Outreach		
Item	Details	Links
Predecessor	Care Management, Benefit Administration, Program Administration, or Program Quality Management processes result in an identified need to perform outreach to contractors.	
Successor	<ol style="list-style-type: none"> 1. Send Outbound Transaction processes distribute communications to the targeted contractor audience. 2. Monitor Performance and Business Activity process measures outreach efficacy. 	
Constraints	Information must address the variations of the target population.	
Failures	N/A	
Performance Measures	Examples of Measures – <ol style="list-style-type: none"> 1. Time to complete process of developing outreach materials = __days 2. Accuracy of outreach materials = __% 3. Successful delivery rate to targeted individuals = __% 	

CO4 Support Contractor Grievance and Appeal

Tier 2: Support Contractor Grievance and Appeal		
Item	Details	Links
Description	<p>The Support Contractor Grievance and Appeal business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Contractor Communications process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are distributed to the contractor information file. The contractor is formally notified of the decision via the Send Outbound Transaction process.</p> <p>This process supports the Program Quality Management business area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.</p> <p>NOTE: States may define “grievance” and “appeal” differently, perhaps because of state laws.</p> <p>*This process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal for example when an application is denied.</p>	<p>Business Area: Tier 1: Contractor Management; Tier 2: Contractor Support</p>
Trigger Event	Receipt of grievance or appeal of adverse decision data set from Receive Inbound Transaction process.	
Result	Final disposition of grievance or appeal sent to the contractor via the Send Outbound Transaction process.	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive grievance or appeal via Receive Inbound Transaction Process 2. Situational: Request additional documentation 3. Determine status as initial, second, or expedited. 4. Triage to appropriate personnel for review. 5. Perform research and analysis 6. Schedule hearing within required time. 	
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 7. Conduct hearing within required time. 8. Determine disposition. 9. End: Request that the Manage Contractor Communication process prepare a formal disposition to be sent to the contractor via Send Outbound Transaction process. <p>NOTE: Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.</p>	

CO4 Support Contractor Grievance and Appeal

Tier 2: Support Contractor Grievance and Appeal		
Item	Details	Links
Shared Data	<ol style="list-style-type: none"> 1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Contractor Registry: Contracted service areas, MCO provider network and other provider data 3. Provider Registry: Provider data, such as type, location, availability. 4. Grievance and Appeal Case File Repository 	
Predecessor	Receipt of appeal data set from Receive Inbound Transaction process.	
Successor	Formally notify applicant or member via Send Outbound Transaction process.	
Constraints	States have different requirements for evidence and the process for conducting the grievance/appeals cases. They have different rules for assigning outcome status and state-specific consequences.	
Failures	N/A	
Performance Measures	<p>Examples of Measures –</p> <ol style="list-style-type: none"> 1. Time to complete process: normal grievance/appeal = __days; second appeal = __ days; expedited appeal = __hours. 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __% 	

Member Management

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	Details	Links
Description	<p>The Determine Eligibility business process receives eligibility application data set from the Receive Inbound Transaction process; checks for status (e.g., new, resubmission, duplicate), establishes type of eligible (e.g., children and parents, disabled, elderly, or other); screens for required fields, edits required fields, verifies applicant information with external entities, assigns an ID, establishes eligibility categories and hierarchy, associates with benefit packages, and produces notifications.</p> <p>See Attachment A for details associated with specific groups of eligibility, i.e., Children and Parents, Disabled, Elderly.</p> <p>NOTE: A majority of states accept the designation of eligibility from other agencies (SSI, TANF, SCHIP, other), in which case this business process will not be used by the Medicaid agency for those individuals. In these situations, Medicaid receives and stores the member information sent from other sources in the Member Registry. This may require conversion of the data.</p> <p>However, this process will be used by the other states which require the TANF, disabled, elderly applicant to apply for Medicaid, and where the Medicaid agency determines eligibility for state-only programs.</p>	<p>Business Process Model location: Tier 1: Member Management Tier 2: Eligibility Determination</p>
Trigger Event	<ol style="list-style-type: none"> 1. Interaction-based Trigger Event: <ol style="list-style-type: none"> a. Original eligibility application data set b. Resubmitted eligibility application data set c. Eligibility application cancellation data set 2. User specified Trigger Event (date): Time for redetermination <ol style="list-style-type: none"> a. Spend down calculation or data b. Also for cost share 	<p>Links to other processes: Receive Inbound Transaction</p>
Result	<ol style="list-style-type: none"> 1. Eligibility application status set to: accepted, denied, or pending for research/additional information 2. Eligibility is determined as approved, denied or pending for additional information or review (clarify between step 1 and step 2) 3. Member eligibility record completed and sent to Manage Member Information process to be loaded into Member Registry. 	<p>Links to other processes: Manage Member Information Manage Applicant and Member Communication</p>

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	Details	Links
Result (Cont'd)	<ol style="list-style-type: none"> 4. Member notification prepared and data set sent to the Manage Applicant and Member Communication process 5. Tracking information regarding the interchange as need for the Determine Eligibility process, measuring performance and business activity monitoring. 6. Feed into Enroll Member for Managed Care 	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive eligibility application data set (cover all trigger events i.e., time events) 2. Verify status of application (new, resubmit, duplicate, redetermination) 3. Validate syntax and semantic requirements associated with children and families eligibility application. Business rules identify fatal and non-fatal errors and associated error messages. 4. Validate completeness and required fields — business rules identify mandated fields and apply edits 5. Meet with applicant or member head of household as scheduled by the Manage Applicant and Member Communication process. Review member application and additional information provided by member in determination process, which entails completing the following steps as appropriate. 6. Verify applicant name, date of birth, gender, Social Security Number, and other required demographic elements — Validate applicant information with sources, e.g., Vital Statistics file, SSA 7. Verify Income Eligibility — Apply income standard (dollar amount) and methodology (rules for what is counted); verify applicant documentation (e.g., bank statements) with financial institutions. 8. For Spend Down applicants, verify that qualifying medical care expenditures amount has been met 9. Verify Resource Eligibility — Apply resource standard (dollar amount) and methodology (rules for which assets are counted and how they count); verify applicant documentation 10. Verify Immigrant Status — Determine which immigrant classification the individual belongs to (if applicable); verify documentation 	Business rules vary by state

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	Details	Links
<p>Business Process Steps (Cont'd)</p>	<ol style="list-style-type: none"> 11. Verify Residency — Check documentation proving residency in the state ([Note, if institutionalized in another state, eligibility stays with state of residency: [verify State policy on the]) 12. Verify Other Coverage — Validate information supplied by applicant; verify with other coverage sources not referenced by applicant 13. For Elderly Applicants, verify the following: <ol style="list-style-type: none"> a. Determine Transfer of Resources — Determine if a transfer has occurred and compute the number of months before Medicaid benefits can begin based on the value of the transferred resources b. Verify Institutional vs. Non-Institutional Status — Institutionalization or community care status calls for different eligibility rules c. Determine if Spousal Impoverishment Applies — If one spouse remains in the community and the other is institutionalized, the community spouse's resources and income may be disregarded 14. For Other Elderly, determine eligibility for QMB, SLMB 15. For Disabled Applicants, Verify Disability — Determine that applicant meets disability qualifications, e.g., demonstrates HIV diagnosis or other conditions: blind, quadriplegia, mental illness or retardation, Down's syndrome, and other debilitating conditions 16. For Pregnant Women, Verify Pregnancy 17. Apply Composite Eligibility Determination Rules — Summation of all rules determines if applicant is eligible or not, and if eligible, for which category of eligibility 18. Determine Other Eligibility Categories — Identify other eligibility categories for which applicant may be eligible and determine hierarchy of applicability in the case of multiple eligibilities; this includes eligibility for other programs, e.g., Disability, Veterans Administration, Indian Health Service 19. Assign I.D. 	<p>Add assign eligibility date.</p>
<p>Business Process Steps (Cont'd)</p>	<ol style="list-style-type: none"> 20. Assign Eligibility Category(ies) [some children in family may not be eligible for Medicaid, e.g., too old to qualify for income level] 21. Associate Benefit Packages [Need State-specific rules on which eligible categories map to which benefit packages and services ; do benefit packages include Manage Care? Which are optional?] 22. Load eligibility information into Member Registry 23. End: Request that the Manage Applicant and Member Communication process generate notifications 	

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	Details	Links
Shared Data	<p>Member Registry and custodial information; school, special schools tuition)</p> <p>Eligibility Categories and Hierarchy Table</p> <p>Benefit Plans and Associated Services Table</p> <p>TANF eligibility</p> <p>SSI eligibility</p> <p>SSP eligibility</p> <p>Spend down amount data store</p> <p>Veterans Administration</p> <p>Indian Health Service</p> <p>INS</p> <p>Other Insurers and type of coverage</p> <p>Bank account balances</p> <p>Employer records</p> <p>Fraud case file</p> <p>Vital Statistics</p> <p>Aging or Elderly Services</p>	<p>These are internal and external data stores</p>
Predecessor	<ol style="list-style-type: none"> 1. Receive Inbound Transaction process receives paper and electronic applications and generates application data sets 2. Manage Applicant and Member Communication process schedules the face to face or phone interview, receives an application, or receives a referral: logs in request and prepares a package of eligibility information which is sent to the Determine Eligibility Process. Spend down, presumptive eligibility (pregnancy), user present data to case worker?, Newborns – automatically eligible is mom is eligible 	<p>Receive Inbound Transaction; Manage Applicant & Member Communication</p>
Successor	<ol style="list-style-type: none"> 1. Notify Applicant, Member being redetermined or Guardian 2. Update Member Registry 	<p>Manage Applicant & Member Communication</p>
Constraints	<p>A majority of Medicaid agencies accept the eligibility determination of the SSA for the SSI population. Many states delegate TANF eligibility to a sister agency. Some Medicaid agencies choose to perform the eligibility determination function themselves. States are responsible for non-SSI-linked eligibility. States differ in the rules applied to eligibility determination and the order in which the rules are applied. In all cases, determining disability status is time consuming.</p>	<p>Business rules differ by state</p>

ME Determine Eligibility

Tier 3: Determine Eligibility [△ NMEH-Reviewed]		
Item	Details	Links
Failures	<p>A member eligibility application may fail at the following steps:</p> <ol style="list-style-type: none"> 1. Duplicate or cancelled application 2. Applicant or Member fails to keep scheduled appointment or provide additional information as requested 3. Required fields missing or not correct 4. Does not meet basic qualifications, e.g., disability status 5. Fails income eligibility 6. Fails resource eligibility 7. Fails immigrant qualifications 8. Fails residency 9. Verification with internal sources <p>Note that the Determinate Eligibility Process does not fail because the applicant is found ineligible, only because conditions are such that the process cannot be successfully completed.</p>	Failure notifications
Performance Measures	<p>Examples of Measures</p> <ol style="list-style-type: none"> 1. Time to complete eligibility determination process = ___ days 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = ___% or less 	

ME Enroll Member

Tier 3: Enroll Member [△ NMEH-Reviewed]		
Item	Details	Links
Description	<p>The Enroll Member business process receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible (e.g., managed care, HIPP, waiver), loads the enrollment outcome data into the Member and Contractor Registries, and produces notifications to the member and the contractor. Either the Agency or enrollment brokers may perform some or all of the steps in this process. See Attachment A for details associated with specific groups of eligibility, i.e., managed care, HIPP, waiver.</p> <p>NOTE: There is a separate business process for Disenroll Member.</p>	Business Process Model location: Member Management
Trigger Event	<ol style="list-style-type: none"> 1. Enrollment application data set that may accompany initial or redetermination of eligibility 2. Enrollment application data set submitted subsequent to being determined eligible in response to Open Enrollment period for MCO, change in demographics, e.g., residence, because important provider no longer contracts with current program/MCO, or because of change in health status, e.g., the member applies for ADAP or Maternity Case Management. 	Links to other processes: Determine Eligibility
Result	<ol style="list-style-type: none"> 1. Member is enrolled in specific programs 2. Perform Applicant/Member Communication process prepares member notification data set 3. Manage Contractor Communication prepares health service contractor notification data set 4. Outbound Transaction process notifies member by paper/phone/fax/email, or health services contractor via paper/phone/fax or 834 5. Manage Member Information loads member enrollment data loaded into Member Registry 6. Notification to other eligibility systems 	Links to other processes: <ol style="list-style-type: none"> 1. Manage Applicant & Member Communication 2. Manage Member Information 3. Manage Contractor Communications 4. Send Outbound Transactions

ME Enroll Member

Tier 3: Enroll Member [△ NMEH-Reviewed]		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive member eligibility data and enrollment application from the Determine Eligibility process. 2. Verify demographic data required for the enrollment in specific programs, e.g., age, diagnosis, disability 3. Verify that residence is appropriate for the enrollment 4. Offer choice where appropriate (e.g., MCO, PCP) 5. Generate request that enrollment information be loaded by the Manage Member Information process into Member Registry 6. Notify other eligibility systems 7. Check for duplicate member 8. End: Request that member and contractor be notified 	Business rules vary by state
Shared Data	<ol style="list-style-type: none"> 1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Registry: Contracted service areas, MCO provider network and other provider data 4. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence 5. GIS data 	
Predecessor	Determine Eligibility process approves applicant as eligible for one or more program and benefit packages.	
Successor	<ol style="list-style-type: none"> 1. Manage Applicant and Member Communication 2. Manage Contractor Communication 3. Outbound Transaction 4. Manage Member Information 5. Manage Provider Communication 	
Constraints	State may have different programs and different enrollment criteria, or may use enrollment brokers for some or all of the process steps. States may require non-HIPAA covered contractors to use the 834 Enrollment Transaction or may rely on state-specific formats for contractor notification	Business rules differ by state

ME Enroll Member

Tier 3: Enroll Member [△ NMEH-Reviewed]		
Item	Details	Links
Failures	<p>A member may fail to enroll in a specific program for the following reasons:</p> <ol style="list-style-type: none"> 1. Duplicate enrollment application — Disregard second application 2. Required fields missing or not correct — Request additional or corrected information from Member or Determine Eligibility process [NOTE: These fields are those required for enrollment in the special program, not for Medicaid eligibility.] 3. Does not meet basic qualifications, e.g., disability status, diagnosis — Notify member about denial and about other programs in which they may enroll if appropriate 4. Fails residency requirements — Notify member of other programs for which they are qualified based on residence 5. Enrollment information is not loaded into Member and Contractor Registries 6. Notification fails to reach member or contractor 	Failure notifications
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: successful applicant is enrolled within __ days 2. Accuracy of decisions 3. Consistency of decisions and disposition 4. Error rate is __% or less 	

ME Disenroll Member

Tier 3: Disenroll Member		
Item	Details	Links
Description	<p>The Disenroll Member business process is responsible for managing the termination of a member’s enrollment in a program, including:</p> <ul style="list-style-type: none"> ■ Processing of eligibility terminations and requests for e.g., disenrollment <ul style="list-style-type: none"> – Submitted by the member, a program provider or contractor – Disenrollment based on member’s death; failure to meet enrollment criteria, such as a change in health or financial status, or change of residency outside of service area – As requested by another Business Area, e.g., Prepare Member Payment Invoice process for continued failure to pay premiums or Program Integrity for fraud and abuse – Mass Disenrollment due to termination of program provider or contractor ■ Validation that the termination meets state rules ■ Requesting that the Manage Member Information process load new and changed disenrollment information ■ Prompting the Manage Member Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including <ul style="list-style-type: none"> – The Capitation and Premium and Member Payment Management Areas business processes about changed Member Registry information for payment preparation – The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights <p>Enrollment brokers may perform some of the steps in this process</p>	<p>Business Process Model location: Member Management</p>

ME Disenroll Member

Tier 3: Disenroll Member		
Item	Details	Links
Trigger Event	<ol style="list-style-type: none"> 1. State-transition based: Receipt of disenrollment request data set from the Determine Eligibility process <ol style="list-style-type: none"> a. In conjunction with a redetermination of eligibility for Medicaid in which the member is found to be no longer eligible b. As a result of a denial of eligibility for a program in addition to Medicaid based on health status, e.g., the member applies for ADAP, Home and Community Based Services, or Maternity Case Management 2. Interaction Trigger Event: Receipt of a disenrollment request from <ol style="list-style-type: none"> a. A Member to change MCO, PCCM, or waiver provider, which are forwarded by the Perform Applicant and Member Communication process: <ol style="list-style-type: none"> (1) During an Open Enrollment period (2) As permitted by state rules, e.g., <ol style="list-style-type: none"> (a) Due to change in residence (b) Because an important provider no longer contracts with current program/MCO (c) The contract with the member's MCO is terminated (d) As a result of successfully appealing auto-assignment (e) The member has issues with the MCO, PCCM, or waiver provider that may impact quality of care b. A program provider or contractor due to issues with the member such as moving out of service area, fraud and abuse, disruptive behavior, non-compliance or death, which are forwarded by the Manage Provider and Manage Contractor Communications 	Links to other processes: <ol style="list-style-type: none"> 1. Determine Eligibility 2. Perform Applicant & Member Communication 3. Manage Provider Communication 4. Manage Contractor Communications

ME Disenroll Member

Tier 3: Disenroll Member		
Item	Details	Links
Result	<ol style="list-style-type: none"> 1. Member is either or both <ol style="list-style-type: none"> a. Disenrolled from specific programs or from specific program contractors or providers b. Offered enrollment in alternative programs or with alternative contractors where the member meets program criteria 2. Member Registry is updated, disenrollment data required for operations is made available, and alerts are broadcast to subscribing processes such as Care Management the Capitation and Premium Preparation and Member Payment Management Areas business processes, the Perform Applicant and Member Outreach, and the Communications processes 3. Member and program contractor or provider is notified about disenrollment results 4. Capitation or premium payments reflect the change in enrollment 	Links to other processes: <ol style="list-style-type: none"> 1. Perform Applicant & Member Communication 2. Manage Member Information 3. Manage Contractor Communication 4. Manage Provider Communication 5. Care Management, Establish Case 6. Capitation and Premium Payment Area business processes
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive member eligibility termination data and disenrollment requests from the Determine Eligibility, the Perform Applicant and Member Communication, the Manage Provider Communication or the Manage Contractor Communications processes 2. Assign unique identifier for tracking 3. Track processing status of eligibility termination and disenrollment requests (e.g., new, resubmission, duplicate) and validating application meets state submission rules, e.g., syntax/semantic conformance [If resubmit, message will contain only updated data and some steps below may be skipped; if duplicate, process terminates and result messages are produced – see Failures.] Other communications may be requests to cancel application, and to deactivate or reactivate enrollment 4. Verify demographic data does not meet specific program enrollment requirements as specified in the Benefit Repository, e.g., age, diagnosis, disability 5. Verify that residence is not appropriate for the enrollment 	Business rules vary by state

ME Disenroll Member

Tier 3: Disenroll Member		
Item	Details	Links
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 6. Produce disenrollment record data set and request that the Manage Member Information process load disenrollment record into Member Registry 7. Alert the Manage Applicant and Member Communication, Manage Provider Communication, and Manage Contractor Communication that new or updated disenrollment information has been loaded into the Member Registry and request that these processes prepare notifications to the affected parties. This will likely include notification of appeal rights 8. Alerts Perform Applicant and Member Outreach process to provide outreach and education materials needed by members who have been disenrolled in accordance with rules 9. End: Alert the appropriate Operations Management Area processes, e.g., the Capitation and Premium Payment Area to prepare enrollment payment reflecting deletions; and the Prepare Member Premium Invoice business process to cease billing member for premiums 	
Shared Data	<ol style="list-style-type: none"> 1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Registry: Contracted service areas, MCO provider network and other provider data 4. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence 	
Predecessor	<ul style="list-style-type: none"> ■ Determine Eligibility ■ Manage Applicant and Member Communication ■ Manage Contractor Communication ■ Manage Provider Communication 	
Successor	<ul style="list-style-type: none"> ■ Manage Member Information ■ Manage Applicant and Member Communication ■ Manage Contractor Communications ■ Manage Provider Communication ■ Capitation and Premium Payment Area business processes 	
Constraints	State may have different programs and enrollment change or termination criteria, or may use enrollment brokers for some or all of the process steps.	Business rules differ by state

ME Disenroll Member

Tier 3: Disenroll Member		
Item	Details	Links
Failures	<p>A member eligibility application may fail at the following steps:</p> <ol style="list-style-type: none"> 1. Duplicate disenrollment requests — Disregard second request 2. Required fields missing or not correct — Request additional or corrected information from Member or Determine Eligibility process 3. Denial of Member request for disenrollment from one program, provider or contractor due to changes in circumstances, such as residence, health status, or provider access issues because the request does not meet state rules or the member is not eligible for enrollment in an alternative program 4. Denial of program, provider, or contractor request to disenroll the member due to, e.g., changed residence, health status or compliance issues because the request does not meet state rules 5. Member successfully appeals disenrollment 6. Disenrollment information is not loaded into Member Registry 7. Successor processes do not receive or respond according to rules about disenrollment notification 8. Notification fails to reach member or program provider or contractor 	Failure notifications
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: successful applicant is enrolled within __ days 2. Accuracy of decisions 3. Consistency of decisions and disposition 4. Error rate is __% or less 	

ME Inquire Member Eligibility

Tier 3: Inquire Member Eligibility [△ NMEH-Reviewed]		
Item	Details	Links
Description	<p>The Inquire Member Eligibility business process receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process, which generates the outbound Eligibility Verification Response Transaction. This transaction will, at minimum, indicate whether the member is eligible for some health benefit plan coverage under Medicaid, in accordance with HIPAA. This transaction may include more detailed information about the Medicaid programs, specific benefits and services, and the provider(s) from which the member may received covered services.</p> <p>NOTE: This process does not include Member requests for eligibility verification. Member initiated requests are handled by the Manage Applicant and Member Communication process.</p>	<p>Business Process Model location: Tier 1: Member Management Tier 2: Member Information Management</p>
Trigger Event	Interaction-based Trigger Event: Receipt of Eligibility Verification Request data set from Receive Inbound Transaction process.	Receive Inbound Transaction
Result	<ol style="list-style-type: none"> 1. Eligibility Verification Response data set routed to Send Outbound Transaction process. Data set may include information such as eligibility start/end dates, programs the member is enrolled in, the providers that may render services, and covered benefits and services. 2. Tracking information regarding the interchange as need for the Inquire Member Eligibility process, measuring performance and business activity monitoring. 	Send Outbound Transaction
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receipt of Eligibility Verification Request data set from Receive Inbound Transaction process. 2. Determine Request status as initial or duplicate using rules to determine if the requester is “fishing”. 3. Verify authorization of the requester to receive requested eligibility information 4. Query Member Registry for requested information 5. Process Response 6. Log Response 7. End: Prepare response data set for the Send Outbound Transaction process <p>NOTE: Security and Privacy verifications are handled by the Inbound, Outbound Transaction processes.</p>	<p>Links Receive Inbound Transaction Manage Member Information Send Outbound Transaction</p>
Shared Data	<ol style="list-style-type: none"> 1. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. 2. Data sets received and sent based on the HIPAA X12 270/271 and NCPDP Telecommunications Guide v 5.1 and Batch Guide v 1.0. 	
Predecessor	Receive Inbound Transaction process	

ME Inquire Member Eligibility

Tier 3: Inquire Member Eligibility [△ NMEH-Reviewed]		
Item	Details	Links
Successor	Send Outbound Transaction process	
Constraints	Eligibility verification request can ask for verification at the categorical, program, provider, or benefit level per X12 270 depending on trading partner agreements. For example, some trading partner agreements may support only a minimal response concerning eligibility status for general health benefit plan coverage (categorical level) as required by HIPAA.	
Failures	<ol style="list-style-type: none"> 1. Process unable to process Eligibility Inquiry Request 2. Requester not authorized to receive requested information at the level asked, e.g., eligibility for mental health program, however requester may receive more general information such as verification of eligibility for health benefit plan coverage. <p>NOTE: Responses that a member is not eligible or is not active are not failures to process the request.</p>	Failure notifications such as the X12 824 or 271
Performance Measures	<ol style="list-style-type: none"> 1. Time to verify eligibility and generate response data set: e.g., Real Time response = within __ seconds, Batch Response = within __ hours of receipt of Trigger data set 2. Response Accuracy = ___% 3. Error rate = __% or less 	

ME Manage Member Information

Tier 3: Manage Member Information		
Item	Details	Links
Description	<p>The Manage Member Information business process is responsible for managing all operational aspects of the Member Registry, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid.</p> <p>The Member Registry is the Medicaid enterprise “source of truth” for member demographic, financial, socio-economic, and health status information. A member’s registry record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services.</p> <p>In addition, the Member Registry stores records about and tracks the processing of eligibility applications and determinations, program enrollment and disenrollment; the member’s covered services, and all communications, e.g., outreach and EOBs, and interactions related to any grievance/appeal.</p> <p>The Member Registry may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend-down information.</p> <p>Business processes that generate applicant or member information send requests to the Member Registry to add, delete, or change this information in registry records. The Member Registry validates data upload requests, applies instructions, and tracks activity.</p> <p>The Member Registry provides access to member records to applications and users via batch record transfers, e.g., for Medicare Crossover claims processing, responses to queries, e.g., for eligibility verification and Operations Management Area, and “publish and subscribe” services for business processes that track member eligibility, e.g., Care Management and Perform Applicant and Member Outreach.</p> <p>Among the business processes that will interface with the Member Registry are:</p> <ul style="list-style-type: none"> ■ The Determine Eligibility process, which checks the Member Registry for status (e.g., new, resubmission, duplicate) and sends completed member eligibility record to be loaded into Member Registry. ■ The Enroll and Disenroll Member processes, which send and retrieve member information relating to these processes, such as member’s ability to access providers, and plan and provider preferences 	<p>Business Process Model location: Business Area: Member Management Tier 1: Member Information Management</p>

ME Manage Member Information

Tier 3: Manage Member Information		
Item	Details	Links
Description (Cont'd)	<ul style="list-style-type: none"> ■ The Perform Applicant and Member, Manage Provider, and Manage Contractor Communications processes, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring these communication processes to prepare notifications ■ The Perform Applicant and Member Outreach, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring provision of outreach and education to the affected applicant or member ■ The Perform Applicant and Member Communication process, which schedules the face to face or phone interview, receives an application, or receives a referral: logs in request and prepares a package of eligibility information which is sent to the Determine Eligibility Process ■ All Operations Management business processes, e.g., Manage Member Payment, Edit Claim/Encounter, and Authorize Service ■ The Maintain Benefit/Reference Information process, which is the Member Registry's source of benefit package information ■ The Manage Program Information business process, which consolidates key enterprise data for use in reporting, analysis and decision support ■ Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Member Registry for member information ■ Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Member Registry 	

ME Manage Member Information

Tier 3: Manage Member Information		
Item	Details	Links
Trigger Event	<ul style="list-style-type: none"> ■ State transition trigger event: Receipt of request to add, delete, change Member information or pointers to member information records from <ul style="list-style-type: none"> – Member Management Business Area processes: Determine Eligibility, Enroll and Disenroll Member, Perform Applicant and Member Outreach, Manage Applicant and Member Communication, or Manage Applicant and Member Grievance and Appeal – The Maintain Benefit/Reference Information process, which is the Member Registry’s source of benefit package information that may be changed during the member’s enrollment span – Operations Management Business Area processes: Manage Payment Information (e.g., claims/encounters, COB, TPL, cost recoveries, HIPP, and service authorization), Calculate Spend-down, or Process Member Premium Invoice – Care and Program Integrity Management Manage Repository processes ■ Interaction-based Trigger Event: Receipt of a query about data in one or more applicant or member records from enterprise business processes, or from authorized external parties, e.g., for verification of member information. ■ Environmental Trigger Event: Scheduled transmission of member information records or pointers to member information on a periodic or real time basis to the Capitation and Premium Payment Area processes for payment preparation, and the Manage Program Information business process 	<p>Links to other processes: All Member Business Processes plus: Calculate Spend-down Process Member Premium Invoice Capitation and Premium Payment Area Business Processes Care Management Establish Case Program Integrity Identify and Establish Care and Manage Repositories</p>
Result	<p>The Member Registry is loaded with new or updated member information for the purposes of:</p> <ol style="list-style-type: none"> 1. Responding to queries from authorized users and applications 2. Supplying all Member Management Area business processes with applicant or member information as needed to, e.g., detect duplicate applications; schedule redetermination; conduct open enrollment processing; perform member outreach and communication functions, etc. 3. Supplying all Operations Management Area business processes with applicant or member information needed to, e.g., edit claims and encounters, process member payment invoices, prepare EOB, conduct cost recoveries, etc. 4. Sending records or pointers to the Manage Program Information business process 	

ME Manage Member Information

Tier 3: Manage Member Information		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receives data from Member Management Area and relevant Operations Management business processes 2. Loads data into the Member Registry, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Provides access to records as required by Member Management Area business processes workflow 4. Provides access to records as requested by other authorized business processes and users 5. Provides data to the Manage Program Information business process on a real time or periodic basis in update or snapshot mode 6. End: Archive data in accordance with state and federal record retention requirements 	Each state will specify its data requirements and rules for each step
Shared Data	Data needed to record information about the following: Member demographic, financial, socio-economic, and health status data; information related to requests for and determinations of eligibility, appointment scheduling, eligibility verification, and communications concerning outreach and education, programs, eligibility, enrollment, services, access, etc.; services requested and services provided; member payment and spend-down information; as well as interactions related to any grievance/appeal	
Predecessor	Inbound Transaction Processing for eligibility and enrollment applications, communications, scheduling requests Member Management business processes supplying data to the Member Registry, including Determine Eligibility, Enroll and Disenroll Member, Perform Applicant and Member Outreach, Manage Applicant and Member Communication, and Manage Applicant and Member Grievance and Appeal. Operations Management business processes supplying data to the Member Registry including Calculate Spend-down, and Process Member Premium Invoice business processes.	

ME Manage Member Information

Tier 3: Manage Member Information		
Item	Details	Links
Successor	<p>Outbound Transaction Processing for eligibility and enrollment applications, communications, scheduling requests</p> <p>Member Management business processes accessing data in the Member Registry, including Determine Eligibility, Enroll and Disenroll Member, Perform Applicant and Member Outreach, Manage Applicant and Member Communication, and Manage Applicant and Member Grievance and Appeal Operations Management Area business processes, including Edit and Audit Claims and Encounters business processes; Prepare Health Insurance Premium, Medicare Premium and Capitation Payment business processes; Process Member Premium Invoice, prepare EOB, and Calculate Spend-down business processes; and all Cost Recovery business processes</p> <p>Care Management Establish and Manage Case business processes</p> <p>Manage Program Information business process</p> <p>Program Integrity Identify and Establish Case business processes may need to access member data from the Member Registry rather than from the Program Information Repository</p>	
Constraints	State specific work flows will determine which processes load and access the Member Registry and by which interactions and messages (e.g., query/response, batch uploads, publish and subscribe, etc.); and the data content and structure of registry records	
Failures	Member Registry fails to load or update appropriately; or fails to make registry data available or available in correct format.	Results messages: Error Messages or Null Query Response
Performance Measures	<ol style="list-style-type: none"> 1. Time to verify eligibility and generate response data set: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Response Accuracy = ___% 3. Error rate = __% or less 	

ME Manage Applicant and Member Communication

Tier 3: Manage Applicant and Member Communication [△ NMEH-Reviewed]		
Item	Details	Links
Description	<p>The Manage Applicant and Member Communication business process receives requests for information, appointments and assistance from prospective and current members' communications such as inquiries related to eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and produced for distribution via Send Outbound Transaction process.</p> <p>NOTE: Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to <i>individuals</i>, i.e., bi-directional communication. Also included are scheduled communications such as Member ID cards, redetermination notifications, or formal program notifications such as the dispositions of grievances and appeals. The <i>Perform Applicant and Member Outreach</i> process targets both prospective and current Member <i>populations</i> for distribution of information about programs, policies, and health issues.</p>	<p>Business Process Model location: Member Management Tier 1: Member Support</p>
Trigger Event	<ul style="list-style-type: none"> ■ Interaction-based Trigger Events: <ul style="list-style-type: none"> - Inquiry from current or prospective member. - Request to send information packages such as eligibility applications and health plan open enrollment forms. - Request to schedule an appointment to determine eligibility. - Request for assistance, such as a request to change PCCM, health plan, or lock-in provider. - Requests from other processes to develop and produce communications for members such as notifications from the Determine Eligibility process such as requests for additional information, new eligible information packages, or determination decisions. ■ User-based Trigger Events: <ul style="list-style-type: none"> - Scheduled time to send information, e.g., within 24 hours of new member enrollment; redetermination notification, and monthly communications such as enrollment cards. - Follow-up on requests from grievances 	<p>Receive Inbound Transaction; Determine Eligibility; Manage Applicant and Member Communication</p>

ME Manage Applicant and Member Communication

Tier 3: Manage Applicant and Member Communication [△ NMEH-Reviewed]		
Item	Details	Links
Result	<ol style="list-style-type: none"> 1. Member receives appropriate assistance, communications, appointment and/or information packages. 2. Tracking information regarding the interchange as needed for the Manage Applicant and Member Communication process and the Monitor Performance and Business Activity process to ensure that applicants and members receive the information they need 3. Tracking information from requests from members 	Send Outbound Transaction
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive request for communication from Receive Inbound Transaction process or from other processes such as Determine Eligibility or Manage Member Grievance and Appeal to prepare communications 2. Log and track communications request and response processing data 3. Research/develop communication that is linguistically, culturally, and competency appropriate 4. Prepare/package communication 5. Perform Review or Quality Check communication 6. End: Send member communications and information packages to be distributed by the Send Outbound Transaction process. [NOTE: May simply route inbound messages to other processes without creating outbound.] 	
Shared Data	<ol style="list-style-type: none"> 1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Registry: Contracted service areas, MCO provider network and other provider data 4. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence 5. Claims History 	Member, Provider, Contractor Registries, Benefit Repository, Program Information
Predecessor	<ol style="list-style-type: none"> 1. Receive Inbound Transaction 2. Determine Eligibility 3. Manage Member Grievance and Appeal 4. Manage Population & Member Outreach 	Receive Inbound Transaction; Determine Eligibility; Manage Member Grievance and Appeal
Successor	Send Outbound Transaction process	Send Outbound Transactions

ME Manage Applicant and Member Communication

Tier 3: Manage Applicant and Member Communication [△ NMEH-Reviewed]		
Item	Details	Links
Constraints	Communications requested will vary depending on programs supported by the agency, e.g., managed care, waiver, PCCM and lock-in programs require provider assignment which members may request to change. If eligibility is determined outside the agency, then this process may not be requested to send applications or schedule eligibility determination appointments.	State specific business rules
Failures	<ol style="list-style-type: none"> 1. Inability to provide linguistically, culturally, or competency appropriate information 2. Communication barriers such as lack of internet or phone access; failure to access needed or requested information 3. Delivery failures due to erroneous contact information or lack of contact information for mobile communities such as migrant workers or the homeless population. 4. Member does not respond to communication 	Failure Notice
Performance Measures	<p>Examples of Measures –</p> <ol style="list-style-type: none"> 1. Time to complete process of developing communications: By phone __ minutes; by email ____ hours; by mail __days 2. Accuracy of communications = __% 3. Successful delivery rate to targeted individuals = ____% 	

ME Manage Member Grievance and Appeal

Tier 3: Manage Member Grievance and Appeal [△ NMEH-Reviewed]		
Item	Details	Links
Description	<p>The Manage Member Grievance and Appeal business process handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Applicant and Member Communication process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file. The applicant or member is formally notified of the decision via the Send Outbound Transaction Process.</p> <p>This process supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. In some states, if the applicant or member does not agree with the Agency's disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or member is urgent, the appeal may be expedited.</p> <p>NOTE: States may define "grievance" and "appeal" differently, perhaps because of state laws. States must enforce the Balance Budget Act requirements for grievance and appeals processes in their MCO contracts at 42 CFR Part 438.400. They may adopt these for non-MCO programs.</p>	Business Process Model location: Tier 1: Member Management; Tier 2: Member Support
Trigger Event	Receipt of grievance or appeal of adverse decision data set from Receive Inbound Transaction process.	Receive Inbound Transaction
Result	Final disposition of grievance or appeal sent to the applicant or member via the Send Outbound Transaction process.	Send Outbound Transaction
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive grievance or appeal via Receive Inbound Transaction Process 2. Situational: Request additional documentation 3. Determine status as initial, second, or expedited. 	

ME Manage Member Grievance and Appeal

Tier 3: Manage Member Grievance and Appeal [△ NMEH-Reviewed]		
Item	Details	Links
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 4. Triage to appropriate personnel for review. 5. Schedule hearing within required time. 6. Conduct hearing within required time. 7. Determine disposition. 8. End: Request that the Manage Applicant and Member Communication process prepare a formal disposition to be sent to the applicant or member via Send Outbound Transaction process. 	
Shared Data	<ol style="list-style-type: none"> 1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Registry: Contracted service areas, MCO provider network and other provider data 4. Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence 	
Predecessor	Receipt of appeal data set from Receive Inbound Transaction process.	Receive Inbound Transaction
Successor	Formally notify applicant or member via Send Outbound Transaction process.	Send Outbound Transaction
Constraints	In addition to general rights of Medicaid and Medicare beneficiaries under federal law, state policy and state law constrain the legal issues about which applicants and members may file grievances and appeals, provide additional rights, e.g., for second or expedited appeal, and set time limits for disposing of the appeal.	
Failures	<ol style="list-style-type: none"> 1. Applicant or member withdraws grievance/appeal 2. Grievances and appeals fail to be processed according to federal or state law. 	
Performance Measures	<p>Examples of Measures –</p> <ol style="list-style-type: none"> 1. Time to complete process: normal grievance/appeal = __days; second appeal = __days; expedited appeal = __hours 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __% 	

ME Perform Population and Member Outreach

Tier 3: Perform Population and Member Outreach [△ NMEH-Reviewed]		
Item	Details	Links
Description	<p>The Perform Population and Member Outreach business process originates internally within the Agency for purposes such as:</p> <ul style="list-style-type: none"> ■ Notifying prospective applicants and current members about new benefit packages and population health initiatives ■ New initiatives from Program Administration ■ Indicators of underserved populations from the Monitor Performance and Business Activity process (Program Management). <p>It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children’s Health Insurance Program (SCHIP).</p> <p>Outreach information is developed for targeted populations that have been identified by analyzing member data. Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction and the Manage Business Relationship Communication process. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.</p> <p>NOTE: The Perform Population and Member Outreach process targets both prospective and current Member <u>populations</u> for distribution of information about programs, policies, and health issues. Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to <u>individuals</u>, i.e., bi-directional communication.</p>	<p>Business Process Model location: Tier 1: Member Management Tier 2: Member Support</p>

ME Perform Population and Member Outreach

Tier 3: Perform Population and Member Outreach [△ NMEH-Reviewed]		
Item	Details	Links
Trigger Event	<p>State-transition based Trigger Events:</p> <ul style="list-style-type: none"> ■ Implementation of population health initiatives such as ESPDT and enrollment campaigns for SCHIP. ■ Scheduled communications related to current programs such as open enrollment ■ Changes to existing plans or benefit packages ■ Call center volumes exceed a threshold on a particular issue ■ New program policies and procedures. ■ Changes to existing policies and procedures. ■ Critical need in a specific target population. ■ Identification of new and currently served populations in need of services or access. ■ Other healthcare or Federal mandates (e.g., Privacy notice) 	Care Management; Benefit Administration, Program Administration; Program Quality Management
Result	Outreach communications, such as mailings brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements; are produced and distributed to targeted populations or individuals.	Send Outbound Transaction; Manage Business Relationship Communications
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Target population is identified and defined by analyzing member service data, performance measures, feedback from community, and policy directives 2. Receive request for outreach materials or communications 3. Approve ore deny (or modify) decisions to develop outreach communications 4. Determine development approach (internal and external or both) outreach materials, approaches, success measures 5. Approval of outreach materials 6. Distribute outreach materials or communications Send outreach communications to be distributed through various mediums supported by the Send Outbound Transaction process, or the Manage Business Relationship Communications process (to be distributed to target populations by community resource and advocacy groups, providers, and other entities that work with the target population) 7. Outreach communications production and distribution are tracked and materials archived <p>[Steps may differ in a State-wide managed care setting.]</p>	

ME Perform Population and Member Outreach

Tier 3: Perform Population and Member Outreach [△ NMEH-Reviewed]		
Item	Details	Links
Shared Data	<ol style="list-style-type: none"> Care Management population health data Program Quality Management quality measure data, e.g., CAPHS and HEDIS measures Benefit Repository: Services and provider types covered; program policy; and health plan contractor information Member Registry: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded Contractor Registry: Contracted service areas, MCO provider network and other provider data Provider Registry: Provider data, such as type, location, availability, gender and linguistic and cultural competence Claims history 	Member, Provider, Contractor Registries, Benefit Repository, Program Information
Predecessor	Care Management, Benefit Administration, Program Administration, or Program Quality Management processes result in need to perform outreach to prospective members.	Care Management; Benefit Administration; Program Quality Management
Successor	<ol style="list-style-type: none"> Send Outbound Transaction and/or Manage Business Relationship Communication processes distribute communications to the target population Monitor Performance and Business Activity Process measures Outreach efficacy 	Send Outbound Transaction; Manage Business Relationship Communications
Constraints	Communications and information packages must address the needs of the target population. Materials must be linguistically and culturally appropriate, legally compliant, appropriate to the targeted group, meet financial guidelines (re: cost to produce and distribute). Other constraints may be agency priority, availability of resources, and accuracy of member contact information.	State specific business rules
Failures	<ol style="list-style-type: none"> Inability to provide linguistically, culturally, or competency appropriate information Communication barriers such as lack of internet or phone access; failure to access needed or requested information Delivery failures due to erroneous contact information or lack of contact information for mobile communities such as migrant workers or the homeless population 	Failure Notice
Performance Measures	<p>Examples of Measures –</p> <ol style="list-style-type: none"> Time to complete process of developing outreach materials from receipt of request to completion of distribution = __ days Accuracy of outreach materials = __% Successful delivery rate to targeted individuals = ___% 	

Operations Management

OM1 Authorize Service

Tier 3: Authorize Service		
Item	Details	Links
Description	<p>The Authorize Service business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, surgeries, tests, drugs, durable medical equipment, and institutional days of stay. It is primarily used in a fee-for-service setting.</p> <p>The pre-approved is a care management function and begins with receiving a referral request data set from an EDI, Paper/Fax, phone, or 278 Health Care Services Review Inbound Transaction Process. Requests are evaluated based on urgency and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state), validating key data, and ensuring that requested referral is appropriate and medically necessary. After review, a referral is approved, modified, denied or pended for additional information. The appropriate response data set for the outbound 278 Response Transaction, 277 Request for additional information or paper/fax notifications/correspondence is sent to the provider using the Send Outbound Transaction through Manage Provider Communication.</p> <p>A post-approved referral is an editing/auditing function that requires review of referral information after the referral has been made. A review may consist of: verifying referral documentation to ensure a referral for services was appropriate and medically necessary; validating provider type and specialty information to ensure a referral is in line with agency policies and procedures. Post-approved validation typically occurs in the Edit Claims/Encounter or Audit Claims/Encounter processes.</p> <p>NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, Inpatient, Out-of-State Services, and Emergencies.</p>	<p>Business Process Model location: Operations Management: Tier 2: Service Review NOTE: There are three types of Service Authorization: Authorize Treatment Plan, Authorize Referral, and Authorize Service</p>
Trigger Event	<p>Interaction-based Trigger Event: A service authorization request data set is received from the Receive Inbound Transaction Process.</p> <p>State Transition Service Authorization Trigger Event: Receipt of data set containing referral information.</p>	

OM1 Authorize Service

Tier 3: Authorize Service		
Item	Details	Links
Result	An Authorize Service data set is sent to the: <ol style="list-style-type: none"> Send Outbound Transaction process for generation into an outbound transaction Maintain Benefits/Repository process for access during the claim adjudication process. Manage Provider Communication Care Management 	Links to: Manage Provider Communication Care Management
Business Process Steps	<ol style="list-style-type: none"> Start: Receive data set from Receive Inbound Transaction Process Assign a tracking number Prioritize Service Authorization Request Validate member eligibility Validate requesting and servicing providers Validate service coverage and referral requirements Validate diagnosis code Validate procedure code Check for medical appropriateness Check against current referrals for duplicates Validate completeness of supporting documentation Deny based on insufficient/erroneous data or referral for service not medically necessary and send via Manage Provider Communication Pend the referral request based on need for additional information – send request for additional information data set to Send Outbound Transaction Process for generation of paper/phone/fax correspondence or an X12 277 Request for Additional Information Transaction Approve referral request (this includes approved with modifications and send approval response data set to Send Outbound Transaction Process for generation of paper/phone/fax correspondence or an X12 278 Service Review Response End: Load review results into Benefits/Reference repository for access during adjudication processes. 	
Shared Data	<ol style="list-style-type: none"> Provider Registry – Provider ID Number Member Registry – Eligibility Benefit Package Data Service Data Reference Repository- carries diagnosis and procedure code data Correspondence Data 	
Predecessor	This business process is preceded by the Receive Inbound Transaction Process.	

OM1 Authorize Service

Tier 3: Authorize Service		
Item	Details	Links
Successor	<ol style="list-style-type: none"> 1. Downstream business processes related to claims adjudication processes e.g., Audit Claim/Encounter process 2. Manage Provider Communication 3. Maintain Benefits/Reference Repository 	
Constraints	The Authorize Service Request data set must conform to the format and content in accordance with state specific reporting requirements, such as states' HIPAA companion guides.	Business rules differ by state
Failures	N/A	Result messages
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours. 2. Accuracy with which service authorizations are approved 3. Consistency of decisions in approving or denying service authorizations 4. Error rate = __% or less. 	

OM1 Authorize Treatment Plan

Tier 3: Authorize Treatment Plan		
Item	Details	Links
Description	<p>The <i>Authorize Treatment Plan</i> business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan. A Treatment Plan prior-authorizes the named providers and services. The individual providers are pre-approved for the service and do not have to submit their own Service Request. It typically covers many services and spans a length of time. A service request is more limited and focuses on a specific visits, services, or products.</p> <p>The pre-approved treatment plan is a care management function and begins with receiving an authorize treatment plan request data set from either an EDI, Paper/Fax, or phone Inbound Transaction Process, evaluating based on urgency and type of service/taxonomy (speech, physical therapy, home health), validating key data, and ensuring that requested plan of treatment is appropriate and medically necessary. After reviewing; approves, modifies, pends or denies the request and sends the appropriate response data set for the outbound transaction or paper/fax notifications or correspondence from the <i>Manage Provider Communication</i> process or sending a 277 Request for Additional Information to the provider.</p> <p>A post-approved treatment plan is an audit function that reviews pended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.</p>	<p>Business Process Model location: Operations Management: Tier 2: Service Review NOTE: There are three types of Service Authorization: Authorize Treatment Plan, Authorize Referral, and Authorize Service</p>
Trigger Event	<p>Interaction-based Trigger Event: An authorize treatment plan request data set is received from the <i>Receive Inbound Transaction</i> Process.</p> <p>State Transition Treatment Plan Authorization Trigger Event: Receipt of data set containing plan of treatment information.</p>	
Result	<p>An Authorize treatment plan data set is sent to the:</p> <ol style="list-style-type: none"> 1. <i>Send Outbound Transaction</i> process for generation into an outbound transaction. 2. <i>Maintain Benefits/Repository</i> process for access during the claim adjudication process. 3. <i>Manage Provider Communication</i> process to inform the member and the various providers that the plan of treatment has been approved 4. <i>Care Management</i> process so that the treatment plan and services rendered can be monitored. 	<p>Links to:</p> <ol style="list-style-type: none"> 1. Manage Provider Communication 2. Care Management

OM1 Authorize Treatment Plan

Tier 3: Authorize Treatment Plan		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive data set from <i>Receive Inbound Transaction</i> Process 2. Assign a tracking number 3. Prioritize authorize plan of treatment request 4. Validate member eligibility 5. Validate requesting and servicing providers 6. Validate service coverage and plan of treatment requirements 7. Validate diagnosis code 8. Validate procedure code 9. Check for medical appropriateness 10. Check against currently authorized treatment plans for duplicates 11. Validate completeness of supporting documentation 12. Deny based on insufficient/erroneous data or treatment plan identifying services not medically necessary and send via <i>Manage Provider Communication</i> 13. Pend the plan of treatment request based on need for additional information – send request for additional information data set to <i>Send Outbound Transaction</i> Process for generation of paper/phone/fax correspondence or an X12 277 Request for Additional Information Transaction 14. Approve plan of treatment request (this includes approved with modifications and send approval response data set to <i>Send Outbound Transaction</i> Process for generation of paper/phone/fax correspondence or EDI transaction. 15. End: Load review results into <i>Maintain Benefits/Reference</i> repository for access during adjudication audit process. 	Links to: <ol style="list-style-type: none"> 1. Receive Inbound Transaction 2. Provider Registry 3. Member Registry 4. Program Information Repository
Shared Data	<ol style="list-style-type: none"> 1. Provider Registry – Provider ID Number 2. Member Registry – Eligibility 3. Benefit Package Data 4. Service Data 5. Reference Repository- carries diagnosis and procedure code data 6. Correspondence Data 	
Predecessor	This business process is preceded by the <i>Receive Inbound Transaction</i> Process.	

OM1 Authorize Treatment Plan

Tier 3: Authorize Treatment Plan		
Item	Details	Links
Successor	<ol style="list-style-type: none">1. Downstream business processes related to claims adjudication processes e.g., <i>Audit Claim/Encounter</i> process2. <i>Manage Provider Communication</i>3. <i>Maintain Benefits/Reference Repository</i>	
Constraints	The Authorize Treatment Plan Request data set must conform to the format and content in accordance with state specific reporting requirements, such as states' HIPAA companion guides.	Business rules differ by state
Failures	N/A	Result messages
Performance Measures	<ol style="list-style-type: none">1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours.2. Accuracy with which service authorizations are approved3. Consistency of decisions in approving or denying service authorizations4. Error rate = __ % or less.	

OM2 Apply Claim Attachment

Tier 4: Apply Claim Attachment		
Item	Details	Links
Description	<p>This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) from the Edit Claim/Encounter or Audit Claim/Encounter process or has been sent by the provider (unsolicited) from the Receive Inbound Transaction process, linking it with a trace number to associated claim, stapling to a claim or pending the attachment data set for a predetermined time period set by edit and/or audit process rules, validating application level edits, determining if the data set provides the additional information necessary to adjudicate the claim, and if yes, moving the attachment with claim to the next adjudication process; if no, move to payment processing as a denied claim or trigger a request for additional information, and purging an attachment data set after a predetermined time period set by edit or audit process rules if no claim is found.</p> <p>NOTE: If no claim is found, the attachment data set is pending for a predetermined time period in accordance with state specific business rules. After this time period, the attachment data set is purged.</p>	<p>Business Process Model location: Tier 2: Payment Management Tier 3: Claim Encounter Adjudication</p>
Trigger Event	<p>Interaction-based Trigger Event: Receipt of attachment data set from the Receive Inbound Transaction process for either a solicited or unsolicited attachment transaction, e.g., the X12 275/HL7 Claims Attachment Transaction.</p>	<p>Links to previous E2E threads: Inbound Transaction Processing</p>
Result	<p>A validated attachment data set (from either a solicited X12 277 Request for Additional Information or unsolicited X12 275 Additional Information to Support a Health Care Claim/Encounter data set sent by the provider) from the Receive Inbound Transaction process that can be accepted and associated with a claim, or rejected, pending awaiting the receipt of a claim, or purged after a predetermined time. A solicited or unsolicited attachment that passes the Edit Process rules will move to the Audit Process. A solicited or unsolicited attachment that passes the Audit Process rules will move to the Pricing Process. An attachment that fails either will move to Payment Processing as a denied claim or trigger another request via e.g., an X12 277 Request for Additional Information.</p>	<p>Links to subsequent E2E threads: Adjudication Edit, Audit & Pricing</p>

OM2 Apply Claim Attachment

Tier 4: Apply Claim Attachment		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive attachment data set derived from attachment transaction such as the X12 275/HL7 Claims Attachment from the Receive Inbound Transaction Process 2. Link with trace number to associated claim when claim is found 3. When claim is found, validate application level edits such as provider, member, and benefit information, and association with previous submissions 4. Electronically staple to associated claim 5. Determine whether the attachment supplies the additional information as required by state business rules 6. If "yes" then move attachment along with claim to next Edit/Audit Adjudication Process, or Price Claim process, depending on where the information is being used. 7. If "no", then: <ol style="list-style-type: none"> a. Send request for additional information X12 277 through the Send Outbound Transaction (in which case steps 1 through 5 are repeated) or b. Deny the claim 8. End: An attachment data set that completes the edit/audit validation rules with either move to : <ol style="list-style-type: none"> a. Send Outbound Transaction as a paid or denied claim or b. Send Outbound Transaction X12 277 Request for Additional Information. 	
Shared Data	<ol style="list-style-type: none"> 1. Transaction Repository 2. Provider Registry 3. Member Registry 4. Benefit/Reference File 	
Predecessor	Receive Inbound Transaction	
Successor	<ol style="list-style-type: none"> 1. If attachment data meets the Edit/Audit Claim process then move to Price Claim process. 2. If the attachment information fails to meet the Edit or Audit rules, then either <ol style="list-style-type: none"> a. Request for additional information via an X12If the attachment information and move to Send Outbound Transaction Process b. Deny and move to Prepare Remittance Advice/Encounter Report process 	

OM2 Apply Claim Attachment

Tier 4: Apply Claim Attachment		
Item	Details	Links
Constraints	The attachment data set must conform to the format and content in accordance with state specific reporting requirements, such as states' HIPAA companion guides and be submitted with valid data content that is required based on several criterion e.g., type of claim, type of service, provider type and member demographic. The attachment must be consistent with the associated original claim per state rules, and must also contain the correct data for this process to execute.	
Failures	N/A	
Performance Measures	<p>Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours</p> <p>Accuracy with which attachments rules are applied or associated = __%</p> <p>Number of attachments = __% of total claims. (Processing a higher percentage of claims attachments may indicate that a state is able to utilize more clinical data when determining whether a claim meets state payment rules).</p> <p>Error rate of correctly re-associating attachment data = __% or less.</p>	

OM2 Apply Mass Adjustment

Tier 4: Apply Mass Adjustment		
Item	Details	Links
Description	<p>The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the claims by claim/bill type or HCPCS, CPT, Revenue Code(s), or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that will reverse the paid claims and repay correctly. This business process often affects multiple providers as well as multiple claims.</p> <p>NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment involves many claims within a range of dates submitted by multiple providers.</p>	<p>Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Claims and Encounter Adjudication</p>
Trigger Event	<p>Interaction-based Trigger Event Receipt or notification of retroactive rate or program changes from the Receive Inbound Transaction process.</p>	<p>Links to previous business processes: Receive Inbound Transaction Process</p>
Result	<p>The results of the Apply Mass Adjustment process are a validated mass adjustment data set (stream) that can be applied to claims.</p>	<p>Links to other E2E threads:</p>
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receipt or notification of retroactive rate, program changes or retroactive changes in member eligibility. 2. Identify the parameters necessary to locate claims 3. Enter parameters into system 4. Apply the predetermined set of parameters that will reverse the paid claims 5. Produce mass adjustment request report 6. Review the mass adjustment report for validity and accuracy 7. Produce the requested mass adjustment data set 8. End: Release mass adjustment for final payment and recoupments and send to the Send Outbound Transaction 	
Shared Data	<p>Provider Registry Member Registry Transaction History File</p>	<p>These can be internal or external data stores.</p>
Predecessor	<p>Receive Inbound Transaction process.</p>	
Successor	<p>Edit, Audit, Price Claims/Encounters Prepare Claims/Encounters RA Data Set Manage Payment History</p>	

OM2 Apply Mass Adjustment

Tier 4: Apply Mass Adjustment		
Item	Details	Links
Constraints	The mass adjustment must correctly identify claims to be adjusted. Processes may vary by state.	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none">1. Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours2. Accuracy with which edit, audit and pricing rules are applied = ___%3. Error rate = ___% or less.	

OM2 Audit Claim/Encounter [this process is combined with **OM2 Edit Claim/Encounter**]

Tier 4: Audit Claim/Encounter		
Item	Details	Links
Description	<p>The Audit Claim/Encounter E2E business process receives a validated original or adjustment claim data set from the Edit Claim/Encounter process and Checks Payment History Repository for duplicate processed claims/encounters and life time limits</p> <p>Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity a Suspends data sets that fail audits for internal review, corrections, or additional information</p> <p>Sends successfully audited data sets to the Price Claim/Value Encounter process</p> <p>All claim/encounter types must go through most of the steps within the Audit Claim/Encounter process with some variance of business rules and data. See Constraints.</p> <p>NOTE: This E2E is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter processes.</p>	<p>Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Claim/Encounter Adjudication</p>
Trigger Event	<p>State-transition Trigger Event: A claim/encounter data set (received from Edit Claims/Encounter process.)</p>	<p>Links to previous E2E threads: Edit Process</p>
Result	<ol style="list-style-type: none"> 1. Successfully Audited claim/encounter data set (sent to the Price Claim/Value Encounter process) 2. Rejected claim/encounter data set and Audit error report (sent to the Prepare Remittance Advice/Encounter Report process) 3. Resolved suspended claim/encounter data set (If favorable, sent to the Price Claim/Value Encounter process. If unfavorable, sent with Audit error report to the Prepare Remittance Advice/Encounter Report process) 	<p>Links to other E2E threads: Price Claim/Value Encounter Prepare Remittance Advice/Encounter Report Send Outbound Transaction processes</p>
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive claim/encounter data set from the Edit Claim/Encounter process 2. Check Payment History Repository for duplicate processed claims/encounters using search key data such as ICN, date of service, provider and member demographics, service, and diagnosis codes 	

OM2 Audit Claim/Encounter [this process is combined with **OM2 Edit Claim/Encounter**]

Tier 4: Audit Claim/Encounter		
Item	Details	Links
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 3. Check Payment History Repository for Life Time Limits for services, cost and units 4. For Claims: Verify Authorized Service (prior authorization) Number to ensure available units; validate relation to claim and appropriateness of service. For Encounters: Verify the appropriateness of the service authorization against the MCO contract, e.g., overly stringent service authorization requirement for EPSDT or maternity services that might indicate underutilization practices 5. Check Clinical Appropriateness of the services provided based on clinical, case and disease management protocols 6. Perform Prospective Payment Integrity Check 7. End: Send successfully audited claim/encounter data set to the Price Claim/Value Encounter process 	
Shared Data	<ol style="list-style-type: none"> 1. Provider Registry data: Used in performing prospective program Integrity e.g., HIPDB and Medicare/Medicaid sanctions 2. Member Registry data: e.g., member health status data for checking medical appropriateness of services 3. Benefit Repository: e.g., procedures requiring service authorization, units and funding limits for authorized services, life-time limit rules by benefit package 4. Payment History Repository: search key data such as ICN, date of service, provider and member demographics, service, and diagnosis codes 	
Predecessor	Edit Claim/Encounter process	Edit Claim/Encounter process
Successor	<ol style="list-style-type: none"> 1. Price Claim/Value Encounter process (if the claim/encounter data set successfully passes the Audit Claim/Encounter process) 2. Prepare Remittance Advice/Encounter Report process (If the claim/encounter data set is rejected) 3. Apply Attachment process (if the claim data set is suspended with a request for additional information) 	Price Claim/Value Encounter, Apply Attachment, Prepare Remittance Advice/Encounter Report processes
Constraints	All claim/encounter types must go through most of the steps within the Audit Claim/Encounter process with some variance of business rules and data. Types include Institutional, Professional, Dental, Pharmacy, and Waiver claims/encounters; Medicare Crossover and Medicare Part D pharmacy claims, COB claims received from payers secondary to Medicaid, e.g., for IHS eligibles; TPL cost avoidance claims and “anticipated” pay-and-chase claims (those required to be paid because of service type). Auditing variances include audits on services	

OM2 Audit Claim/Encounter [this process is combined with **OM2 Edit Claim/Encounter**]

Tier 4: Audit Claim/Encounter		
Item	Details	Links
Failures	<p>The following steps can result in failure:</p> <p>Audit Failures: Claim/encounter data set has fatal audit error. For Example:</p> <ol style="list-style-type: none"> 1. Duplicate Claims 2. Lack of Service Authorization 3. Invalidate relation to claim and appropriateness of service 4. Medically inappropriate claim/encounter services (based on clinical, case and disease management protocols) 5. Failed Prospective Payment Integrity Check, e.g., the provider is sanctioned by HIPDB, Medicare or Medicaid or the Monitor Performance and Business Activity process detects utilization outliers and alerts the Audit Claims/Encounter process. <p>Suspended Claim/Encounter Failures: Claim/encounter data set has missing or incorrect data that does not constitute a fatal audit error</p> <p>Result: Suspended claim/encounter data set and either:</p> <ol style="list-style-type: none"> 1. Conduct Internal review to find missing or correct data 2. Request that the Outbound Transaction process send the submitter a notification of the Audit failure needing correction using, e.g., an Unsolicited 277 Claim Status Report transaction 3. Request that the Outbound Transaction process send the submitter a request for additional information using, e.g., the 277 Request for Additional Information transaction 	<p>Failure Notifications: Paper Remittance Advice; 835; Encounter Report to MCO; Unsolicited 277; 275 Request for Additional Information</p>
Failures (Cont'd)	<p>Suspended until the claim/encounter data set either:</p> <ol style="list-style-type: none"> 1. Validated to pass the audit in question by internal review 2. Validated to pass the audit based on corrected information submitted in response to an error notification 3. Validated to pass the audit based on additional information submitted in response to a request, such as the 277 Request for Additional Information. Note that this request is generated as a data set by the Apply Attachment, which will review the response to validate that the additional information submitted is sufficient to pass the audit. <p>Suspended claim/encounter data sets that are resolved favorably are sent to the Price Claims/Value Encounter process</p> <p>Suspended claims/encounters that are resubmitted as corrections are processed as if original</p> <p>Suspended claim/encounter data sets that are not resolved favorably are sent to the Prepare Remittance Advice/Encounter Report process with an Audit error report. These include failure because the additional information requested for a suspended claim/encounter is not received or is inadequate or fails to satisfy the audit.</p>	

OM2 Audit Claim/Encounter [this process is combined with **OM2 Edit Claim/Encounter**]

Tier 4: Audit Claim/Encounter		
Item	Details	Links
Performance Measures	<ol style="list-style-type: none">1. Time to complete Audit process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours2. Accuracy with which audits are applied = ___%3. Consistency of decisions on suspended claims/encounters = ___%4. Error rate = __% or less	

OM2 Edit Claim/Encounter [this process is combined with **OM2 Audit Claim/Encounter**]

Tier 4: Edit Claim/Encounter		
Item	Details	Links
Description	<p>The Edit Claim/Encounter E2E business process receives an original or an adjustment claim/encounter data set from the Receive Inbound Transaction process and</p> <ul style="list-style-type: none"> ■ Determines its submission status ■ Validates edits, service coverage, TPL, coding ■ Populates the data set with pricing information <p>Sends validated data sets to Audit Claim/Encounter process and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process</p> <p>All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data. See Constraints.</p> <p>NOTE: This E2E is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter processes.</p> <p>NOTE: The Edit Claim/Encounter process does not apply to:</p> <ul style="list-style-type: none"> ■ Point of Sale, which requires that Edit, Audit, and other processes be integrated, or ■ Direct Data Entry, On-line adjudication, or Web-enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data. 	<p>Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Claim/Encounter Adjudication</p>
Trigger Event	<p>State-transition Trigger Event: A claim/encounter data set (received from the Receive Inbound Transaction process. Includes both paper and EDI).</p>	<p>Links to previous E2E threads: Receive Inbound Transaction process</p>
Result	<ol style="list-style-type: none"> 1. Validated claim/encounter data set (sent to the Audit Claim/Encounter process) 2. Resolved suspended claim/encounter data set (If favorable, sent to the Audit Claim/Encounter process. If unfavorable, sent with Edit error report to the Prepare Remittance Advice/Encounter Report process) 	<p>Links to other E2E threads: Audit Claim/Encounter Prepare Remittance Advice/Encounter Report Send Outbound Transaction processes</p>

OM2 Edit Claim/Encounter [this process is combined with **OM2 Audit Claim/Encounter**]

Tier 4: Edit Claim/Encounter		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive claim/encounter data set from the <i>Inbound Transaction</i> process 2. Determines its status as initial, adjustment to a processed claim/encounter (based on the resubmit flag with a previously assigned ICN), or a duplicate submission that is already in the adjudication process but not yet completed and loaded into payment history (using a unique Patient Account Number) 3. Validate that claim/encounter submission meets filing deadlines based on service dates. 4. Validate provider information in edited fields, e.g., provider taxonomy, NPI, enrollment status, approved to bill for this service 5. Validate member information in edited fields, e.g., Member's eligibility status on the date of service, apply Third party resources to the claim/encounter 6. Validate that service is covered by member's benefit package and apply appropriate rules. For example: <ol style="list-style-type: none"> a. Dental services may not be covered under an adult member benefit package so deny the claim b. A service is covered but the member is enrolled in another health plan that is primary so flag as COB so that claim will be denied (check that encounter was denied for this reason), and, under payer-to-payer model, a COB claim is sent to the primary payer. c. A service is covered and the member has another payer that is primary; however the service is required to be paid by Medicaid regardless, so flag as pay-and-chase in order that the provider will be paid and a pay-and-chase COB claim will be sent to the primary payer 7. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status 8. Validate Correct Coding; apply DRG or APC Groupers; and bundle or unbundle codes. 9. Populate claim data set with state allowed payment amount 10. End: Send accepted claim/encounter data set to <i>Audit Claim/Encounter</i> process 	

OM2 Edit Claim/Encounter [this process is combined with **OM2 Audit Claim/Encounter**]

Tier 4: Edit Claim/Encounter		
Item	Details	Links
Shared Data	<ol style="list-style-type: none"> 1. Provider Registry data: e.g., NPI, provider demographics, provider taxonomy 2. Member Registry data: e.g., member identifier, member demographic data, third party resources 3. Benefit Repository: e.g., covered services, units, life-time limits 4. Reference Repository: e.g., correct coding, valid code set versions, claims filing deadlines 5. Payment History Data Store: e.g., claim/encounter data set with same Patient Account Number 6. Payment History Repository: ICN of original claim/encounter being adjusted by subsequent claim/encounter adjustment submission 	
Predecessor	<ol style="list-style-type: none"> 1. Receive Inbound Paper/Phone/Fax process (if non-EDI claim/encounter) 2. Receive Inbound EDI process (if EDI claim/encounter) 	Receive Inbound Transaction process
Successor	<ol style="list-style-type: none"> 1. Audit Claim/Encounter process (if the claim/encounter data set is validated by the Edit Claim/Encounter process) 2. Prepare Remittance Advice/Encounter Report process (If the claim/encounter data set is rejected) 3. Apply Attachment process (if the claim data set is suspended with a request for additional information) 4. Prepare COB process (if third party resources identified) 	Audit Claim/Encounter, Apply Attachment, Prepare Remittance Advice/Encounter Report processes
Constraints	<p>All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data. Types include Institutional, Professional, Dental, Pharmacy, and Waiver claims/encounters; Medicare Crossover and Medicare Part D pharmacy claims, COB claims received from payers secondary to Medicaid, e.g., for IHS eligibles; TPL cost avoidance claims and “anticipated” pay-and-chase claims (those required to be paid because of service type). Editing variances include edits on services that may be billed by claim/encounter type and by provider taxonomy code; edits on service line codes; pricing; and the additional information that may be required. Editing of encounters may differ from claims because they are typically not priced, and the encounter format and coding rules may be set by managed care contracts and structured to meet MSIS reporting requirements.</p>	
Constraints (Cont'd)	<p>An adjustment to a claim/encounter is an exception use case to this E2E thread that follows the same process path except that it requires a link to the previously submitted and processed claim/encounter in order to reverse the original claim payment or encounter acceptance, and association of the original to the adjustment in the Payment History Repository.</p>	

OM2 Edit Claim/Encounter [this process is combined with **OM2 Audit Claim/Encounter**]

Tier 4: Edit Claim/Encounter		
Item	Details	Links
Failures	<p>The Edit Claim/Encounter process contains a series of potential points of failure. The claim or encounter could fail any edit. Business rules define when one or more edit failures will result in suspending or denying the claim.</p> <p>Edit Failures: Claim/encounter data set has fatal edit error. For Example:</p> <ol style="list-style-type: none"> 1. Duplicate claim/encounter data set is in production 2. Claim/encounter is filed after claim filing deadline 3. Claim/encounter data set has invalid member, provider, or coverage information 4. Service is not covered because not in benefit package, not provided in an approved facility or by an approved provider type 5. Service is not appropriate based on member demographics <p>Edit Failure Result: Rejected claim/encounter data set and Edit error report are sent to the Prepare Remittance Advice/Encounter Report process</p> <p>Suspended Claim/Encounter Failures: Claim/encounter data set has missing or incorrect data that does not constitute a fatal edit error</p> <p>Result: Suspended claim/encounter data set and either:</p> <ol style="list-style-type: none"> 1. Conduct Internal review to find missing or correct data 2. Request that the Outbound Transaction process send the submitter a notification of the Edit failure needing correction using, e.g., an Unsolicited 277 Claim Status Report transaction 3. Request that the Outbound Transaction process send the submitter a request for additional information using, e.g., the 277 Request for Additional Information transaction 	<p>Failure Notifications: Paper Remittance Advice; 835; Encounter Report to MCO; Unsolicited 277; 275 Request for Additional Information</p>

OM2 Edit Claim/Encounter [this process is combined with **OM2 Audit Claim/Encounter**]

Tier 4: Edit Claim/Encounter		
Item	Details	Links
Failures (Cont'd)	<p>Suspended until the claim/encounter data set either:</p> <ol style="list-style-type: none"> Validated to pass the edit in question by internal review Validated to pass the edit based on corrected information submitted in response to an error notification Validated to pass the edit based on additional information submitted in response to a request, such as the 277 Request for Additional Information. Note that this request is generated as a data set by the Apply Attachment, which will review the response to validate that the additional information submitted is sufficient to pass the edit. <p>Suspended claim/encounter data sets that are resolved favorably are sent to the Audit Claims/Encounter process</p> <p>Suspended claims/encounters that are resubmitted as corrections are processed as if original</p> <p>Suspended claim/encounter data sets that are not resolved favorably are sent to the Prepare Remittance Advice/Encounter Report process with an Edit error report. These include failure because the additional information requested for a suspended claim/encounter is not received or is inadequate or fails to satisfy the edit.</p> <p>TPL Failures</p> <ol style="list-style-type: none"> Cost Avoidance TPL identified. Result: Rejected claim data set and Edit error report are sent to the Prepare Remittance Advice/Encounter Report and Prepare COB processes. Rejected Encounter data set is flagged because MCO should perform TPL Prospective Pay and Chase TPL identified. Result: Claim data set is sent to the Audit Claim/Encounter and Prepare COB processes, Rejected Encounter data set is flagged because MCO should perform TPL 	
Performance Measures	<ol style="list-style-type: none"> Time to complete Edit process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours Accuracy with which edits are applied = ___% Consistency of decisions on suspended claims/encounters = ___% Error rate = __% or less 	

OM2 Price Claim/Value Encounter

Tier 4: Price Claim/Value Encounter		
Item	Details	Links
Description	<p>The Price Claim/Value Encounter business process begins with receiving a claim/encounter data set from the Audit Claim/Encounter Process, applying pricing algorithms, calculates managed care and PCCM premiums, decrements service review authorizations, calculates and applies member contributions, and provider advances, deducts liens and recoupments. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Repository from the Manage Payment History process and are accessible to all Business Areas. All Claim Types must go through most of the processes and sub-processes but with different logic.</p> <p>NOTE: An adjustment to a claim is an exception use case to this process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the Payment History Repository.</p>	Business Process Model location:
Trigger Event	<p>State-transition Trigger Event = The Trigger Event for the Price Claim/Value Encounter process begins with receipt of a data set from the Audit Claim/Encounter process.</p> <p>Temporal Trigger Event = Adjudication/Payment cycles are usually set at scheduled intervals, e.g., weekly, bi-weekly, or monthly.</p>	Links to other E2E threads: Claim/Encounter Adjudication Process
Result	<p>An edited and audited claims data set will be priced according to state specific business rules and</p> <ol style="list-style-type: none"> 1. Loaded, along with any attachments to the Manage Payment History process 2. Sent to the Prepare Check/EFT/Encounter Report process 	Links to other E2E threads: Manage Payment History Repository; Prepare Check/EFT/Encounter Report Process
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive audited claim data set from the Audit Claim/Encounter process. 2. Apply pricing algorithm,% of charges, and reductions due to program etc to price loaded by Edit Process 3. Apply pricing algorithm to allowed amount such as percentage of charges or reductions due to state-only program 	

OM2 Price Claim/Value Encounter

Tier 4: Price Claim/Value Encounter		
Item	Details	Links
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 4. Price Diagnosis Related Grouping(s) (DRGs) or Ambulatory Patient Classification(s) (APCs) based on contracted rates 5. Decrement service authorization units or total dollar coverage amount 6. Calculate and apply member contributions such as co-pays or spend-down 7. Calculate and apply provider advances, 8. Deducts liens and recoupments 9. End: Send to the <ol style="list-style-type: none"> a. Prepare Check/EFT/Encounter Report process for payment b. Prepare Remittance Advice/Encounter Reports process c. Manage Payment History process for loading. 	
Shared Data	<ol style="list-style-type: none"> 1. Provider Registry – query/response 2. Member Registry – query/response 3. Benefit/Reference Repository 	
Predecessor	Audit Claim/Encounter process.	
Successor	Prepare Check/EFT/Encounter Report Prepare Remittance Advice/Encounter Reports and Manage Payment History processes.	
Constraints	The Price Claim/Value Encounter process must conform to state specific business rules and pricing algorithms.	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete the process: e.g., Real Time response = within __seconds, Batch Response = within __ hours 2. Accuracy with which the pricing algorithms are applied = __% 3. Consistency with which the pricing algorithms are applied = __% 4. Error rate = __% or less. 	

OM3 Prepare EOB

Tier 4: Prepare EOB		
Item	Details	Links
Description	<p>The Prepare EOB business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs or letters must be provided to the clients within 45 days of payment of claims.</p> <p>This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the Explanation of Benefits (EOBs) and/or notification letters, formatting the data into the required data set, which is sent to the Send Outbound Transaction for generation. The resulting data set is also sent to Manage Applicant and Member Communication.</p> <p>NOTE: This process does not include the handling of returned data nor does it include sending the EOB Sample Data Set.</p>	Business Process Model Location: Operations Management Tier 2: Payment Management Tier 3: Payment and Reporting
Trigger Event	Temporal Trigger Event: The EOB sample data sets are scheduled on a pre-determined timetable.	
Result	The EOB data set is sent to the client via the Send Outbound Transaction .	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Identify sample selection using random sampling methodology 2. Retrieve sample selection data. 3. Prepare the Explanation of Benefits and/or notification letters. 4. Format data into the required data set 5. End: <ol style="list-style-type: none"> a. Send data to the Send Outbound Transaction for generation b. Send data to Manage Applicant and Member Communication for tracking purposes. 	
Shared Data	Member Registry Payment History	
Predecessor	This business process represents the point of entry.	
Successor	Send Outbound Transaction Manage Applicant and Member Communication	
Constraints	The policies and business rules for preparing the EOB sample data set differ by state	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: e.g., Real Time response = within __seconds, Batch Responses = within __ days 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __% 4. Error rate = __% or less. 	

OM3 Prepare Provider EFT/Check

Tier 4: Prepare Provider EFT/Check		
Item	Details	Links
Description	<p>The Prepare Provider EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including:</p> <ul style="list-style-type: none"> ■ Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, HCBS provider claims, and MCO encounters based on inputs such as the priced claim, including any TPL, crossover or member payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and taxes, performance incentives, recoupments, garnishments, and liens per data in the Provider Registry, Agency Accounting and Budget Area rules, including the Manage 1099 process ■ Payroll processing, e.g., for HCBS providers, includes withholding payments for payroll, federal and state taxes, as well as union dues ■ Dispersement of payment from appropriate funding sources per Agency Accounting and Budget Area rules ■ Associating the EFT with a X12 835 electronic remittance advice transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities] ■ Routing the payment per the Provider Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction ■ Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history ■ Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate, e.g., Pharmacy POS 	<p>Business Process Model location: Operations Management Payment Management Payment and Reporting</p>
Trigger Event	<p>State-transition Trigger Event: Receipt of payment data from the Price Claim/Value Encounter process</p>	<p>Links to other processes: Price Claim/Value Encounter process</p>
Result	<p>Provider receives reimbursement, either by EFT or Check</p>	<p>Links to other processes:</p>

OM3 Prepare Provider EFT/Check

Tier 4: Prepare Provider EFT/Check		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receipt of payment data from the Price Claim/Value Encounter process 2. Apply automated or user defined payment calculation rules such as deducting tax per rates in provider files, performance incentives, deduction of garnishments and liens, etc. by accessing data from provider files and generating data to be sent to the Perform Accounting Function process 3. For payroll processing, perform tax withholds and generate data for accounting 4. Disperse funds as specified by the Agency Accounting and Budget Area rules 5. Route payments as specified by the "pay to" instruction in the provider record 6. End: Update the Payment Information Repository, the Perform Accounting Function, and State Financial Management business processes with pending and paid claims transaction accounting detail 	Each state will specify its data requirements and rules for each step
Shared Data	Priced claims data, provider demographic, tax, "pay to" instructions, routing instructions, liens, garnishments, adjustments, incentives; accounting rules, rates, funding sources	
Predecessor	Accounting and Budget Area, Manage Provider Information, Price Claim/Value Encounter; Monitor Performance and Business Activity processes	
Successor	Accounting and Budget Area, Manage Payment Information	
Constraints	States will apply different tax and accounting rules to this process; some will not do payroll processing or have performance incentives; some may associate EFTs with remittance advice transactions	
Failures	Calculation of payment and application of payment adjustments may lack accurate information or be performed inaccurately	Result messages
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less 	

OM3 Prepare Remittance Advice/Encounter Report

Tier 4: Prepare Remittance Advice/Encounter Report		
Item	Details	Links
Description	<p>The Prepare Remittance Advice/Encounter Report business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the pricing, audit and edit processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading.</p> <p>NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.</p>	Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Payment Reporting
Trigger Event	State-transition Trigger Event: Receipt of the claims/encounter data sets from the Edit Claims/Encounters, Audit Claims/Encounters, and Price Claim/Value Encounter processes	Links to other processes: Price Claim/Encounter
Result	Remittance advice or encounter report data set is sent to the <ol style="list-style-type: none"> 1. Send Outbound Transaction Process for generation into an outbound transaction 2. Manage Payment History for loading 3. Manage Provider Information for loading 	Links to other processes: Send Outbound Transaction Process Manage Payment History Manage Provider Information
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive data sets resulting from the pricing, audit and edit processes 2. Perform required data manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim/encounter, such as bundling or unbundling of services 3. Format the results into required output data set 4. End: <ol style="list-style-type: none"> a. Send data set to the Send Outbound Transaction for generation into an outbound transaction b. Send data set to Manage Payment History for loading c. Send total reimbursement amount to the Manage Provider Information process to load in provider record for tax purposes 	
Shared Data	Price Claim/Value Encounter process	
Predecessor	Send Outbound Transaction process	

OM3 Prepare Remittance Advice/Encounter Report

Tier 4: Prepare Remittance Advice/Encounter Report		
Item	Details	Links
Successor	<ol style="list-style-type: none">1. Remittance Advice and Encounter Reporting Business Rules2. Data sets output from the edit, audit and pricing processes	
Constraints	Remittance Advice/Encounter Reports must conform to the format and content in accordance with state specific reporting requirements, such as states' HIPAA companion guides and MSIS reporting requirements, which may differ based on situational fields that are determined by state policy.	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none">1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours2. Accuracy with which remittance advice/encounter report rules are applied = ___%3. Error rate = __% or less	

OM4 Prepare Capitation Premium Payment

Tier 4: Prepare Capitation Premium Payment		
Item	Details	Links
Description	<p>The Prepare Capitation Premium Payment business process includes premiums for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the Maintain Member Information, retrieving the rate data associated with the plan from the Manage Provider Information, formatting the payment data into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Manage Provider Information for updating.</p> <p>NOTE: This process does not include sending the capitation payment data set.</p>	<p>Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Capitation and Premium Processing</p>
Trigger Event	<p>Temporal Trigger Event: The preparing capitation payment data set is scheduled on a pre-determined timetable, usually monthly.</p>	
Result	<p>The prepared capitation payment data set is sent to the Send Outbound Transaction for generation into an outbound transaction and to Manage Payment History for loading and to Manage Provider Information for updating.</p>	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Timetable for scheduled payment 2. Retrieve enrollment 3. Retrieve benefit transaction data 4. Retrieve rate data associated with the contracted plan, PCCM or other capitation program 5. Run algorithms for determining specific capitated rates for individual enrollees. 6. Concatenate rate totals if sending summary premium payment (NOTE: This step is may not be applicable.) 7. Format the data into the required data set 8. End: <ol style="list-style-type: none"> a. Send data set to the Send Outbound Transaction for generation into an outbound transaction b. Send data to Manage Payment History for loading c. Send data to Manage Provider Information for updating 	
Shared Data	<p>Member Registry Provider (Health Plan) Registry Payment History</p>	<p>May be maintained internally or externally</p>
Predecessor	<p>Member is enrolled into a Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs</p>	
Successor	<p>Send Outbound Transaction</p>	

OM4 Prepare Capitation Premium Payment

Tier 4: Prepare Capitation Premium Payment		
Item	Details	Links
Constraints	Preparation of the capitation payment data set must adhere to state specific requirements. These rules will differ by state.	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none">1. Time to complete process: e.g., Real Time response = within __seconds, Batch Response = within __ hours2. Accuracy with which rules are applied = __%3. Error rate = __% or less	

OM4 Prepare Health Insurance Premium Payment

Tier 4: Prepare Health Insurance Premium Payment		
Item	Details	Links
Description	<p>Medicaid agencies are required to pay the private health insurance premiums for members who may have private health insurance benefits through their employers and because of devastating illness are no longer employable and become Medicaid eligible. It can also include children who are Medicaid eligible but also have private health insurance provided by a parent(s). In these circumstances, a cost effective determination is made and a premium is prepared and sent to the member's private health insurance company rather than enrolling them into a Medicaid managed health care plan or pay fee for service claims as submitted by providers.</p> <p>The Process Health Insurance Premium Payments business process begins by receiving eligibility information via referrals from Home and Community Services Offices, schools, community services organizations, or phone calls directly from members; checking for internal eligibility status as well as eligibility with other payers, editing required fields, producing a report, and notifying members. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. The formatted premium payment data set is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Maintain Member Information for updating.</p> <p>NOTE: This process does not include sending the health insurance premium payment data set.</p>	<p>Business Process Model location: Operations Management Tier 2: Payment Management Tier 3: Capitation and Premium Payment</p>
Trigger Event	<p>Temporal Trigger Event: The insurance premium payments are scheduled on a pre-determined timetable, usually monthly.</p>	
Result	<p>The health insurance premium payments data set is sent to the Send Outbound Transaction for generation into an outbound transaction and to Manage Payment History for loading and Maintain Member Information for updating.</p>	<p>Links to other business processes: Send Outbound Transaction Manage Payment History Maintain Member Information</p>

OM4 Prepare Health Insurance Premium Payment

Tier 4: Prepare Health Insurance Premium Payment		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive referral information 2. Check internal and external eligibility information 3. Edit eligibility information 4. Produce a report identifying individuals where paying premiums would be cost effective 5. Produce Member notifications 6. Format the payment report/list 7. End: <ol style="list-style-type: none"> a. Send data set to the Send Outbound Transaction for generation into an outbound transaction b. Send data to Manage Payment History for loading c. Send data to Maintain Member Information for updating. 	
Shared Data	Member Registry Payment History	These are internal and external data stores
Predecessor	Receive Inbound Transaction	
Successor	Send Outbound Transaction	
Constraints	Health Insurance Premium Payments must adhere to state specific laws, regulations and requirements. These rules will differ by state.	
Failures	N/A	Result messages
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours 2. Accuracy with which rules are applied = ___% 3. Error rate = ___% or less 	

OM4 Prepare Medicare Premium Payment

Tier 4: Prepare Medicare Premium Payment		
Item	Details	Links
Description	<p>State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance.</p> <p>The Prepare Medicare Premium Payments business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Payment History and Manage Member Information for loading.</p> <p>NOTE: This process does not include sending the Medicare premium payments EDI transaction.</p>	Business Process Model Location: Operations Management Tier 2: Payment Management Tier 3: Capitation and Premium Processing
Trigger Event	<p>State-transition Trigger Event: The receipt of Medicare eligibility data from the Receive Medicare Dual Eligible Data process.</p> <p>Temporal Trigger Event: The receipt of Medicare eligibility data may be at scheduled intervals stipulated by Trading Partner Agreement.</p>	Links to other processes: Inbound EDI Transactions
Result	<p>Pre-processed data set is sent to the</p> <ol style="list-style-type: none"> 1. Send Outbound Transaction process for generation into an outbound transaction 2. Manage Payment History for loading 3. Manage Member Information for loading. 	Links to other processes: <ol style="list-style-type: none"> 1. Send Outbound Transaction 2. Manage Payment History 3. Manage Member Information

OM4 Prepare Medicare Premium Payment

Tier 4: Prepare Medicare Premium Payment		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive State Data Exchange (SDX) and Beneficiary Data Exchange (BENDEX) eligibility files from the Receive Medicare Dual Eligible business process. 2. Perform a matching process against the Medicaid member registry. 3. Generate two-part buy-in file, one for Medicare Part A and one Medicare Part B 4. Send buy-in file to CMS 5. Receive CMS responses to the buy-in file 6. Process CMS responses to the buy-in file, assessing the file for accuracy and completeness 7. Post buy-in changes to the MMIS member information 8. Produce buy-in reports reflecting potential Medicare eligibles including any additions or deletions to existing eligibility registry as well as other problems 9. Send reports reflecting potential Medicare eligibles, unmatched, and other problems to the Buy-in Administration 10. Research unmatched and problems items to determine appropriate eligibility 11. Update and correct final Medicare buy-in file 12. Verify whether co-insurance and deductible payments are required in addition to the premiums 13. Produce notification to member 14. Format the payment data set 15. End: Send data set to the: <ol style="list-style-type: none"> a. Send Outbound EDI for generation into b. Send Medicare Premium Payment c. Manage Payment History for loading d. Manage Applicant and Member Communication 	
Shared Data	Member Registry Medicare Dual Eligible data	These are internal and external data stores
Predecessor	Receive Medicare Dual Eligible	
Successor	Send Outbound Transaction	
Constraints	The Prepare Medicare Premium Payments business process must adhere to the State policies and business rules that may differ by state.	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours 2. Accuracy with which rules are applied = ___% 3. Consistency with which rules are applied= ___% 4. Error rate = ___% or less. 	

OM6 Prepare Member Premium Invoice

Tier 3: Prepare Member Premium Invoice		
Item	Details	Links
Description	<p>Due to tightening budgets and an ever-increasing population that is covered under the Medicaid umbrella, States began client/member cost-sharing through the collection of premiums for medical coverage. The premium amounts are based on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment.</p> <p>The <i>Prepare Member Premium Invoice</i> business process begins with a timetable (usually monthly) for scheduled invoicing. The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the <i>Send Outbound Transaction</i> process for generation into an outbound transaction. The resulting data set is also sent to <i>Maintain Member Information</i> process for updating.</p> <p>NOTE: This process does not include sending the member premium invoice EDI transaction.</p>	<p>Business Process Model location: Tier 1: Operations Management: Tier 2: Member Payment Management</p>
Trigger Event	Temporal Trigger Event: This trigger event is a monthly timetable for scheduled invoicing.	
Result	A pre-processed member premium invoice data set is sent to the <i>Send Outbound Transaction</i>	Operations Support Send Outbound Transactions
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Monthly timetable for scheduled invoicing 2. Retrieve member premium data 3. Perform required data manipulation 4. Format the results into required output data set 5. Produce member invoice data 6. End: Send data set to the <ol style="list-style-type: none"> a. <i>Send Outbound Transaction</i> for generation into an outbound transaction b. Send data to <i>Maintain Member Information</i> 	
Shared Data	<ol style="list-style-type: none"> 1. Member Registry 	These are internal and external data stores
Predecessor	N/A	
Successor	<i>Perform Accounting Function</i>	
Constraints	The Prepare Member Premium process must conform to the state specific requirements.	Business rules differ by state
Failures	N/A	

OM6 Prepare Member Premium Invoice

Tier 3: Prepare Member Premium Invoice		
Item	Details	Links
Performance Measures	<ol style="list-style-type: none">1. Time to complete process: e.g., Real Time response = within __seconds, Batch Responses = within __ days2. Accuracy of decisions = __%3. Consistency of decisions and disposition = __%4. Error rate = __% or less.	

OM5 Inquire Payment Status

Tier 3: Inquire Payment Status		
Item	Details	Links
Description	The <i>Inquire Payment Status</i> business process begins with receiving a 276 Claim Status Inquiry or via paper, phone, fax or AVR request for the current status of a specified claim(s), calling the payment history data store and/or repository, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response, and sending claim status response data set via the <i>Send Outbound Transaction</i> process.	Business Process Model location: Operations Management; Tier 1: Payment Management; Tier 2: Payment Information Management
Trigger Event	Interaction-based Trigger Event: Receipt of the X12 276 Claim Status Inquiry data set from the <i>Receive Inbound Transaction</i> process.	
Result	The payment status request data set is sent to the <i>Send Outbound Transaction</i> process.	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receives 276 claim status inquiry (similar claim status information can be requested via paper, phone, fax and AVR) 2. Retrieves the payment status information from <i>Manage Payment History</i> (run-time environment) and payment history data repository (persistent data) to obtain required requested data elements (e.g., recipient birth date, recipient gender, recipient last name, recipient first name, member ID, trace number, total claim charge amount, claim service date, ICN number, bill type identifier, medical record number, claim account number) 3. Captures the required claim status responses data 4. Formats the data into the 277 Claim Status Response 5. End: Sends the response data set to the <i>Send Outbound Transaction</i> process 	Business rules vary by state
Shared Data	<i>Manage Payment History</i>	These are internal and external data stores
Predecessor	<i>Receive Inbound Transaction</i>	
Successor	<i>Send Outbound Transaction</i>	
Constraints	Payment Status Inquiry and Response must conform to the format and content in accordance with state specific requirements, such as states' HIPAA companion guides which may differ based on situational fields that are determined by state policy.	Business rules differ by state
Failures	N/A	

OM5 Inquire Payment Status

Tier 3: Inquire Payment Status		
Item	Details	Links
Performance Measures	<ol style="list-style-type: none">1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours2. Accuracy with which payment status rules are applied = __%3. Consistency with which payment status rules are applied = __%4. Error rate = __% or less.	

OM6 Calculate Spend-Down Amount

Tier 3: Calculate Spend-Down Amount		
Item	Details	Links
Description	<p>A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called “spend-down” (see Determine Eligibility).</p> <p>The Calculate Spend-Down Amount business process describes the process by which spend-down amounts are tracked and a client’s responsibility is met through the submission of medical claims. Excess resources are automatically accounted for during the claims processing process resulting in a change of eligibility status once spend-down has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations.</p> <p>The Calculate Spend-Down Amount business process begins with the receipt of member eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services.</p> <p>NOTE: The ‘Calculate Spend-down Amount’ today is primarily a manual process in the Eligibility Determination, Member Payment Management and Maintain Payment History threads. At Level 3 these processes have almost eliminated any use of manual intervention.</p>	<p>Business Process Model location: Operations Management Tier 2: Member Payment Management</p>
Trigger Event	State-transition Trigger Event = member data set.	
Result	Maintain Member Information	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive member eligibility data, including spend-down amount 2. Perform a matching process to identify the appropriate member file 3. Load eligibility data 	
Business Process Steps (Cont’d)	<ol style="list-style-type: none"> 4. Receive claim information 5. Monitor and subtract medical claim amounts from spend-down to insure member responsibility is met. Once spend-down is met 6. Change eligibility status to active 7. End: Send notification that spend-down has been met via the Send Outbound Transaction process to Manage Applicant and Member Communication and to Maintain Member Information for loading. 	

OM6 Calculate Spend-Down Amount

Tier 3: Calculate Spend-Down Amount		
Item	Details	Links
Shared Data	Member Registry Payment History Data	These may be stored internally or externally
Predecessor	Determine Member Eligibility	Eligibility Determination
Successor	Send notification to member that spend-down has been met through Manage Applicant and Member Communication and update Maintain Member Information	Member Information Management
Constraints	The calculate spend-down must conform to the state specific policies which may differ by state.	Business rules differ by state
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within__ hours 2. Accuracy with which rules are applied 3. Consistency of decisions and disposition = __% 4. Error rate = __% or less 	

OM7 Manage Drug Rebate

Tier 3: Manage Drug Rebate		
Item	Details	Links
Description	The Manage Drug Rebate business process describes the process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes receiving quarterly drug rebate data from CMS, comparing it to quarterly payment history data, identifying drug data matches based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer via the Send Outbound Transaction Process sending to Perform Accounting Functions .	Business Process Model location: Tier 1: Operations Management; Tier 2: Cost Recoveries
Trigger Event	Temporal Trigger Event = Receipt of the CMS quarterly drug rebate data set from the Receive Inbound Transaction process.	Links to other E2E threads: Receive Inbound Transaction data set
Result	Drug rebate invoice data set is sent to the <ol style="list-style-type: none"> 1. Send Outbound Transaction process for generation into an outbound transaction. 2. Drug rebate receivables data is sent to the Perform Accounting Functions process 3. Manage Payment History process for loading 	Links to other E2E threads: <ol style="list-style-type: none"> 1. Manage Payment History 2. Perform Accounting Functions 3. Send Outbound Transaction
Business Process Steps	<ol style="list-style-type: none"> 1. Start: The State receives a quarterly file from CMS containing the rebate factors by manufacturer, drug code, and volume 2. The file is compared to the corresponding claims history extract for the same quarter. 3. Drug claims matching the manufacturer and drug codes on the CMS files are selected. 4. Drug claims selected for invoice processing are sorted by manufacturer and drug code. 	Business rules vary by state
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 5. The rebate factor and volume indicators are applied to calculate a rebate total per manufacturer. 6. The invoice data is generated 7. End: Invoice data set is sent to the <ol style="list-style-type: none"> a. Send Outbound Transactions process where it is sent to the manufacturer b. Perform Accounting Functions to prepare for rebate payment from manufacturer c. Manage Payment History process for loading 	

OM7 Manage Drug Rebate

Tier 3: Manage Drug Rebate		
Item	Details	Links
Shared Data	CMS Unit Rebate Amount (URA) Data Payment History Drug Code Data Manufacturer Data	These are internal and external data stores
Predecessor	Receive Inbound Transaction process	
Successor	Send Outbound Transaction process Prepare Accounting Functions process Manage Payment History process	E2E threads:
Constraints	The Manage Drug Rebate process must be in accordance with state specific drug formulary, business rules and reporting requirements which may differ by State.	Business rules differ by state
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete the process. 2. Accuracy with which the Drug Rebate rules are applied = __% 3. Consistency with which the Drug Rebate rules are applied = __% 4. Amount of drug rebate received quarterly 5. Error rate = __% or less. 	

OM7 Manage Estate Recovery

Tier 3: Manage Estate Recovery		
Item	Details	Links
Description	<p>Estate recovery is a process whereby States are required to recover certain Medicaid benefits correctly paid on behalf of an individual. This is done by the filing of liens against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, ICF/MR, or other medical institution.</p> <p>The Manage Estate Recovery business process begins by receiving estate recovery data from multiple sources (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), generating correspondence data set (e.g., demand of notice to probate court via Send Outbound Transaction process, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the Manage Applicant and Member Communication process, opening formal estate recovery case based on estate ownership and value of property, determining value of estate lien, files petition for lien, files estate claim of lien, conducts case follow-up, sending data set to Perform Accounting Functions, releasing the estate lien when recovery is completed, updating Member Registry, and sending to Manage Payment History for loading.</p> <p>NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.</p>	<p>Business Process Model location: Tier 1: Operations Management; Tier 2: Cost Recoveries</p>
Trigger Event	<p>State-transition Trigger Event: Receipt of estate recovery data from Receive Inbound Transaction process, paper, phone, or fax.</p>	<p>Links to other E2E threads: Receive Inbound Transaction.</p>
Result	<p>Manage Estate Recovery data is sent to</p> <ol style="list-style-type: none"> 1. Perform Accounting Functions process 2. Maintain Member Information process 3. Manage Payment History for loading. 	<p>Links to other E2E threads: Manage Payment History Perform Accounting Functions Maintain Member Information</p>

OM7 Manage Estate Recovery

Tier 3: Manage Estate Recovery		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Estate recovery referral data is received via several different sources (e.g., date of death match, probate petition notices, eligibility case worker, nursing homes) 2. Demand notice data is sent to Member Correspondence (e.g., onto probate court) 3. Estate recovery Questionnaire data is sent to Manage Applicant and Member Correspondence (e.g., onto deceased representative) 4. Estate recovery Case is opened 5. Value of estate lien is determined by analyzing all Medicaid claims from age 55 forward (e.g., all paid claims equals lien amount) 6. Estate recovery proceedings data generated (e.g., lien petition, notice of pendency action) and sent to the Send Outbound Transaction process 7. Upon court approval, estate claim of lien is filed 8. Case follow-up occurs (every 30 to 90 days) 9. Estate recovery payment receipt data is sent to the Perform Accounting Functions process and Maintain Member Information process. 10. End: Estate recovery case file is closed and archived upon receipt of full payment and Manage Payment History for loading. 	
Shared Data	Member Registry Payment History Repository	These are internal and external data stores
Predecessor	Receive Inbound Transaction process	
Successor	Send Outbound Transaction process	
Constraints	The Manage Estate Recovery process must be in accordance with state specific policy.	Business rules differ by state
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete the process __. 2. Accuracy with which rules are applied = __% 3. Consistency with which rules are applied = __% 4. Error rate = __% or less 5. Total \$ amount received through estate recoveries. 	

OM7 Manage Recoupment

Tier 3: Manage Recoupment		
Item	Details	Links
Description	<p>The Manage Recoupment business process describes the process of managing provider recoupment. Provider recoupment are initiated by the discovery of an overpayment as the result of a provider utilization review audit, receipt of a claims adjustment request, for situations where monies are owed to the agency due to fraud/abuse, and the involvement of a third party payer.</p> <p>The E2E business thread begins with discovering the overpayment, retrieving claims payment data from the Manage Claims History, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results from the Manage Provider Communication, applying refund in the system from the Perform Accounting Functions, and monitoring payment history until the repayment is satisfied.</p> <p>Recoupments can be collected via check sent by the provider or credited against future payments for services.</p>	Business Process Model location: Tier 1: Operations Management Tier 2: Cost Recoveries
Trigger Event	<p>Interaction-based Trigger Event. This trigger event is the result of a Provider submitting a request for claim adjustment from the Claims/Encounter Adjudication.</p> <p>State-transition Trigger Event. This trigger event is the result of a provider utilization review audit and/or for fraud/abuse from the Identify, Establish, or Manage Case.</p>	Fraud Detection; Inbound EDI Process; Inbound Paper/Phone/Fax Process
Result	<p>Receivables data is sent to Perform Accounting Functions and Manage Payment History.</p>	Perform Accounting Functions; Manage Payment History
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Discover overpayment as the result of a routine adjustment request, a provider utilization review, fraud and abuse case, or involvement of a third party payer. 2. Retrieve claims payment data 3. Initiate recoupment request 4. Notify provider of amount owed and agreed upon method of repayment 5. Apply refund in the system 6. End: Monitor payment history until repayment is satisfied 	
Shared Data	Payment History Repository Provider Registry	These are internal and external data stores

OM7 Manage Recoupment

Tier 3: Manage Recoupment		
Item	Details	Links
Predecessor	<p>Inbound EDI Transaction Process</p> <p>Inbound Paper/Phone/Fax Process</p> <p>Identify Case, Establish Case, Monitor Case</p>	<p>Inbound EDI Transaction Process</p> <p>Inbound Paper/Phone/Fax Transaction Process;</p> <p>Program Integrity Identify Case</p>
Successor	<p>Perform Accounting Functions</p> <p>Manage Payment History</p>	<p>Perform Accounting Functions;</p> <p>Maintain and Manage Payment History</p>
Constraints	<p>Policies and procedures differ by state</p> <p>Integration of the MMIS with state accounting systems can greatly impact the ability of the state to track receivables established by the recoupment.</p>	<p>Business rules differ by state</p>
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete provider recoupment process: e.g., Real Time response = within ___seconds, Batch Response = within ___hours 2. Accuracy with which recoupments are applied = ___ % 3. Consistency of decisions on suspended claims/encounters = ___% 4. Error rate = ___% or less. 	

OM7 Manage Settlement

Tier 3: Manage Settlement		
Item	Details	Links
Description	The Manage Settlement business process begins with requesting annual claims summary data from Manage Payment History , reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates, sending the cost settlement data set via the Send Outbound Transaction process to Manage Provider Communication, Manage Payment History, Manage Rate Setting and sending receivables data to Perform Accounting Functions , and tracking settlement payments.	Business Process Model location: Tier 1: Operations Management; Tier 2: Cost Recoveries
Trigger Event	State-transition Trigger Event: Receipt of provider costs from claims history repository and receipt of Medicare Cost Report. Temporal or Rule-based Trigger Event: Prompt for annual provider cost review.	Links to other E2E threads:
Result	1. Data set with determination of cost settlement data as calculated, reviewed and modified is sent via the Send Outbound Transaction to Manage Provider Communication and Perform Accounting Functions .	Provider Support: Prepare Outgoing Information
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Request annual claims summary data 2. Review provider costs 3. Establish a basis for cost settlements or compliance reviews 4. Receive audited Medicare Cost Report from intermediaries from Receive Inbound Transaction 5. Receive provider cost settlement data from Receive Inbound Transaction. 6. Capture the necessary provider cost settlement data 7. Calculate the final annual cost settlement based on the Medicare Cost Report and prorating for Medicaid services 8. Establish interim reimbursement rates 	

OM7 Manage Settlement

Tier 3: Manage Settlement		
Item	Details	Links
Business Process Steps (Cont'd)	9. Generate cost settlement data identifying the amount of overpayment or underpayment and the reimbursement rates to be considered for the next year 10. Verify the data is correct 11. Produce notifications to providers 12. Send claims summary data via the Send Outbound Transaction to Manage Provider Communication , to Perform Accounting Functions , to Manage Payment History , and to Manage Rate Setting . 13. End: Track cost settlement data until receivable or payable is satisfied.	
Shared Data	Payment History Repository Provider Registry	These are internal and external data stores
Predecessor	Receipt of provider cost reports and Medicare Cost Report	E2E thread:
Successor	1. Manage Provider Communication 2. Perform Accounting Functions 3. Manage Payment History 4. Manage Rate Setting	E2E threads:
Constraints	Cost Settlement data must conform to state specific reporting requirements and MSIS reporting requirements.	Business rules differ by state
Failures	N/A	
Performance Measures	Time to complete the process. Consistency with which rules are applied Accuracy with which rules are applied Amount of overpayment Amount of underpayment	

OM7 Manage TPL Recovery

Tier 3: Manage TPL Recovery		
Item	Details	Links
Description	<p>The Manage TPL Recoveries business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, Attorney's, SUR, Fraud and Abuse units, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from Manage Payment History, creating post-payment recovery files, sending notification data to other payer or provider from the Manage Provider Communication process, receiving payment from provider or third party payer, sending receivable data to Perform Accounting Function, and updating payment history Manage Payment History.</p> <p>NOTE: States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase method.</p>	<p>Business Process Model location: Tier 1: Operations Management; Tier 2: Cost Recoveries</p>
Trigger Event	<p>Interaction-based Trigger Event: Receipt of third party liability data from outside sources, and internal and external eligibility data matches from Verify Member Eligibility.</p>	<p>Links to other E2E threads: Operations Support Tier 1: Transaction Processing</p>
Result	<p>TPL recovery data is sent to the:</p> <ol style="list-style-type: none"> 1. Perform Accounting Function process 2. Manage Payment History process 	<p>Links to other E2E threads: Maintain Payment History Perform Accounting Functions</p>
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive third party liability data 2. Identify the provider or TPL carrier 3. Locate recoverable claims 4. Create post-payment recovery files 5. Send notification to provider or other payer 6. Receive payment from provider or third party payer 7. End: <ol style="list-style-type: none"> a. Send receivables data to the Perform Accounting Functions. b. Send data set to Manage Payment History 	
Shared Data	<p>Member Registry Provider Registry Carrier Data Other Agency Data – DMV, Veterans Administration Indian Health Service INS Fraud case file</p>	

OM7 Manage TPL Recovery

Tier 3: Manage TPL Recovery		
Item	Details	Links
Predecessor	Receipt of third party liability data from outside sources and/or internal or external data matches from Verify Member Eligibility .	
Successor	Maintain Payment History Perform Accounting Functions	Manage/Maintain Payment History Perform Accounting Functions
Constraints	States differ in the rules applied to TPL recoveries. Capabilities related to data matches vary and some states utilize recovery services contractors. Integration of state eligibility information systems with the MMIS also has significant impact on their ability to cost avoid versus cost recover.	Business rules differ by state
Failures	N/A	
Performance Measures	Time to complete process Consistency with which rules are applied. Accuracy with which rules are applied. Total dollars recovered	

Program Integrity Management

PI Identify Candidate Case

Tier 2: Identify Candidate Case		
Item	Details	Links
Description	<p>The Identify Candidate Case business process uses State-specific criteria and rules to identify target populations (e.g., providers, contractors, or beneficiaries), establishes patterns or parameters of acceptable/unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Candidate cases may be identified for:</p> <ul style="list-style-type: none"> ■ Provider utilization review ■ Contractor ■ Beneficiary utilization review ■ Potential fraud ■ Drug utilization review ■ Quality review <p>Each type of case is driven by different State criteria and rules, different relationships, and different data.</p>	<p>Business Process Model location: Tier 1: Program Integrity Management</p>
Trigger Event	<ol style="list-style-type: none"> 1. Scheduled time to scan for candidate cases 2. Request to examine a specific group or individual 3. An alert triggered by other events 	
Result	<ol style="list-style-type: none"> 1. List of candidate cases 2. Record of criteria for targeted population, data selection, parameters used 	
Business Process Steps	<ol style="list-style-type: none"> 1. Identify target population — Define characteristics of the population in which the search will focus: types of provider, location, types of services, patient characteristics, medical conditions 2. Identify data requirements — Specify time period, data elements, data relationships to include in the search 3. Identify rules to apply to the data — Select or create rules including specified norms, statistical deviations, types of patterns, Boolean logic, ratios, percentages 4. Apply rules to target population data — Execute rules and record results 	
Shared Data	<p>Member, provider, and service history data stores Rules database</p>	
Predecessor	<p>Maintain schedule for case identification Receive special request for review Receive warning to investigate</p>	
Successor	<p>Research candidate case</p>	
Constraints	<p>States and programs within states establish different criteria for their investigations. Rules change along with the experience of the state, changes in benefits, new provider types</p>	

PI Identify Candidate Case

Tier 2: Identify Candidate Case		
Item	Details	Links
Failures	N/A	
Performance Measures		

PI Manage Case

Tier 2: Manage Case		
Item	Details	Links
Description	<p>The Manage Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, or beneficiary from the Medicaid program; or the case may be terminated or suspended.</p> <p>Individual State policy determines what evidence is needed to support different types of cases:</p> <ul style="list-style-type: none"> ■ Provider utilization review ■ Provider compliance review ■ Contractor utilization review ■ Contractor compliance review ■ Beneficiary utilization review ■ Investigation of potential fraud ■ Drug utilization review ■ Quality review ■ Performance review <p>Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external investigation.</p>	Business Process Model location: Tier 1: Program Integrity Management
Trigger Event	<ol style="list-style-type: none"> 1. Scheduled time to perform case management 2. Receipt of information requiring case management 3. Special request to perform case management 	
Result	<ol style="list-style-type: none"> 1. Record of documentation 2. Disposition of case 	
Business Process Steps	<ol style="list-style-type: none"> 1. Assign case manager — A case manager is assigned and authorized to manage a case and request additional information 2. Establish case — The case file is opened, a schedule is added, and a reporting framework is established 3. Review case — Examine information associated with the case; request more historical information as needed 4. Notify affected parties — Correspond with providers, beneficiaries, agents, guardians, attorneys, et al to notify them regarding the investigation, their rights, and the right of the Medicaid agency to request documentation 	

PI Manage Case

Tier 2: Manage Case		
Item	Details	Links
Business Process Steps (Cont'd)	5. Conduct inquiries and investigations — Depending on the type of case, different external inquiries will need to be conducted, e.g., <ul style="list-style-type: none"> a. View medical records b. Interview patient c. Validate credentials 6. Document evidence — Evidence is documented in the case file 7. Determine action — Based on evidence gathered, a determination is made to close the case 8. Determine disposition — When research and analysis are completed, the case disposition is reported, e.g., cancel case, claim damages, identify corrective action, terminate membership in Medicaid program	
Shared Data	Member, provider, and service history data stores Rules data base Medical records	
Predecessor	Research Candidate Case	
Successor	Prepare Outgoing Information Support Grievance and Appeals	
Constraints	States and programs within states establish different criteria for their investigations. Rules change along with the experience of the state, changes in benefits, new provider and beneficiary types	
Failures	N/A	
Performance Measures		

Program Management

PG1 Designate Approved Service/Drug Formulary

Tier 3: Designate Approved Service/Drug Formulary		
Item	Details	Links
Description	<p>The <i>Designate Approved Services/Drug Formulary</i> business process begins with a review of new and/or modified service codes or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package.</p> <p>Service, supply and drug codes are reviewed by a team of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and state plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.</p> <p>NOTE: This does not include implementation of <i>Approved Service/Formulary</i>.</p>	<p>Business Process Model location: Tier 1: Program Management Tier 2: Benefit Administration</p>
Trigger Event	<p>State transition based Trigger Event: Receipt of Benefit Package information from <i>Develop and Maintain Benefit Package</i>.</p> <p>Temporal Trigger Event: Annual, Bi-annual, Quarterly or other review of newly established or modified services codes and National Drug Codes as published by maintainers of medical codes.</p>	

PG1 Designate Approved Service/Drug Formulary

Tier 3: Designate Approved Service/Drug Formulary		
Item	Details	Links
Result	<ol style="list-style-type: none"> 1. Approved services and drug formularies are established and defined. 2. Service/NDC codes are approved or denied for inclusion or exclusion in one or more Medicaid Benefit plan. 3. Maintain Benefits/Reference Repository loads approved services and drug formulary registry. 4. Maintain State Plan process updates state plan. 5. Manage Applicant and Member Communication prepares member notification data set 6. Manage Provider Communication prepares provider notification data set 7. Manage Benefit and Reference Information 8. Manage Rate Setting establishes rates for approved services and drug formularies. 	Links to other processes: <ol style="list-style-type: none"> 1. Maintain Benefits/Reference Repository 2. Maintain State Plan 3. Manage Applicant and Member Communication 4. Manage Provider Communication 5. Maintain Benefit and Reference Information 6. Manage Rate Setting
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive new codes 2. Review new coding or changed coding to determine impact to coverage requirements based on current benefit programs. 3. Approve addition or elimination of services or NDC from service/drug formulary. 4. Determine coverage policies. 5. Review and identify changes to State Plan 6. Review and identify changes to regulations. 7. Recommend changes to system tables 8. Produce notification for vendors, providers, and impacted members 9. End: Send notification via the Send Outbound Transaction to <ol style="list-style-type: none"> a. Manage Applicant and Member Communication b. Manage Provider Communication c. Maintain State Plan 	
Shared Data	Drug Formulary Table Service Code Table Benefit Plans and Associated Service Tables Provider Data Program Data	
Predecessor	Receive Inbound Transaction Develop and Maintain Benefit Packages	

PG1 Designate Approved Service/Drug Formulary

Tier 3: Designate Approved Service/Drug Formulary		
Item	Details	Links
Successor	<ol style="list-style-type: none"> 1. Maintain State Plan 2. Manage Applicant and Member Communication 3. Manage Provider Communication 4. Maintain Benefit and Reference Information 5. Manage Rate Setting 6. Send Outbound Transaction 	
Constraints	Most service/drug formularies are established at the state level, policies and procedures may differ from state to state.	
Failures	N/A	Failure Notifications
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = ___% or less 	

PG1 Develop & Maintain Benefit Package

Tier 3: Develop & Maintain Benefit Package		
Item	Details	Links
Description	<p>The Develop & Maintain Benefit Package business process begins with receipt of coverage requirements and recommendations through new or revised: Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations or changes resulting from court decisions. Benefit package requirements are mandated through regulations or other legal channels and must be implemented. Implementation of benefit package recommendations is optional and these requests must be approved, denied or modified.</p> <p>Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including:</p> <ul style="list-style-type: none"> ■ Determination of scope of coverage ■ Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc. ■ Identification of impacted members and trading partners. 	<p>Business Process Model location: Tier 1: Program Management Tier 2: Benefit Administration</p>
Trigger Event	<p>State transition based Trigger Events: New or changed Federal/State legislation, regulations, or policies. Material changes to State law or organization policy/regulations. Court decisions.</p> <p>User based Trigger Event: Annual/bi-annual quality-of-care review.</p>	
Result	<ol style="list-style-type: none"> 1. New benefit package requests approved, denied, or modified. NOTE: This result is only applicable to optional requests. 2. New/modified benefit packages defined 3. Updates to Maintain State Plan 4. Manage Applicant & Member Communication, Manage Provider Communication — notifications sent to impacted business partners, trading partners and/or clients 5. Implementation of new or modified benefits. 	

PG1 Develop & Maintain Benefit Package

Tier 3: Develop & Maintain Benefit Package		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receipt of coverage requirements and/or recommendations identifying new or modified benefits. 2. Analysis of request for feasibility of implementation. 3. Approve, Deny, or modify request. (NOTE This step is only applicable to optional requests). 4. Define coverage requirements including: scope of coverage and eligibility criteria. 5. Amend state plan if necessary. 6. Implementation of new/modified benefit package including system modifications and updating of applicable benefit and service tables. 7. End: Notify impacted parties via Manage Applicant & Member Communication and Manage Provider Communication. 	
Shared Data	Benefit Plans and Associated Service Tables. Provider Data Program Data Member Data	Data can be maintained internally or externally.
Predecessor	Receipt of new legislation or benefit change request via Receive Inbound Transaction	Receipt of new legislation or change request.
Successor	<ol style="list-style-type: none"> 1. Maintain State Plan 2. Manage Applicant and Member Communication 3. Manage Provider Communication 4. Maintain Benefit and Reference Information 5. Designate Approved Services/Drug Formulary 	
Constraints	Many benefit plans are defined at the state level where policies and procedures will differ by state.	
Failures	N/A	Failure Notifications
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% Error rate = __% or less 	

PG1 Manage Rate Setting

Tier 3: Manage Rate Setting		
Item	Details	Links
Description	The Established Rate Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program.	Tier 1: Project Management Tier 2: Benefit Administration
Trigger Event	Scheduled date for new or changed rate, receipt of new/changed rates, or official request for rate update.	
Result	New Rate, with effective date and date span, or "no action" if rate is rejected.	
Business Process Steps	<ol style="list-style-type: none"> 1. START. Receive notification of rate. 2. Change or request for rate change. 3. Request data to verify rate change or research and analyze rate. 4. Validate rate or establish rate. 5. Optional: Perform "what if" impact analysis. 6. END. Create rate update. 	
Shared Data	Any information regarding the service or product association with the rate; history of the rate; selected data for impact analysis.	
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

PG2 Develop Agency Goals and Initiatives

Tier 3: Develop Agency Goals and Initiatives		
Item	Details	Links
Description	The <i>Develop Agency Goals and Initiatives</i> business process periodically assess current mission statement, goals, and objectives to determine if changes are called for. Changes to goals and objectives could be warranted under a new administration or in response to changes in demographics or public opinion; or in response to natural disasters such as Katrina.	Tier 1: Program Management Tier 2: Program Administration
Trigger Event	Receipt of notice that a reviewing of current goals and objectives is warranted.	
Result	New statement of goals and objectives.	
Business Process Steps	<ol style="list-style-type: none"> 1. START. Receive notice that a review of current goals and objectives is warranted. 2. Request. 3. Review. 4. Convene Stakeholders. 5. Develop consensus on changes. 6. END. Publish new statement of goals and objectives. 	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

PG2 Develop and Maintain Program Policy

Tier 3: Develop and Maintain Program Policy		
Item	Details	Links
Description	The <i>Develop and Program Administrative Policy</i> Business Process responds to requests or needs for change in the agency's programs, benefits, or rules, based on federal or state statutes and regulations; governing board or commission directives; QIO findings; federal or state audits; agency decisions; and consumer pressure.	Tier 1: Project Management Tier 2: Program Administration
Trigger Event	Scheduled date for review of policy. Scheduled date to implement new policy or change.	
Result	New or changed policy. New or changed business rules.	
Business Process Steps	<ol style="list-style-type: none"> 1. START. Receive request to add delete, or change policy. 2. Request information to analyze policy. 3. Assess impact of policy on budget, stakeholders, and other benefits. 4. Formulate and publish policy. 5. Hold public hearings. 6. Revise policy. 7. Determine effective date and date span for policy. 8. <u>Optional</u>: Develops training plan for new policy. 9. Develops implementation plan for policy. 10. END. Disseminate policy. 	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

PG2 Maintain State Plan

Tier 3: Maintain State Plan		
Item	Details	Links
Description	The Maintain State Plan business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.	Tier 1: Program Management Tier 2: Program Administration
Trigger Event	Scheduled, periodic date prompt to review and update state plan, unscheduled notification to review and update state plan.	
Result	Modification to state plan.	
Business Process Steps	<ol style="list-style-type: none"> 1. START. Receive prompt or notification to review and update state plan. 2. Review current state plan documentation. 3. Analyze requirements for change to state plan. 4. Research information associated with the change. 5. Analyze impact of the change. 6. Develop state plan modification. 7. Disseminate state plan modification for review and comment. 8. Refine state plan modification. 9. END. Publish state plan modification. 	
Shared Data	Current state plan, information about affected area, "What if" models	
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

PG3 Formulate Budget

Tier 1: Formulate Budget		
Item	Details	Links
Description	The Formulate Budget business process examines the current budget, revenue stream and trends, and expenditures, assesses external factors affecting the program, assesses agency initiatives and plans, models different budget scenarios, and periodically produces a new budget.	Tier 1: Project Management Tier 2: Budget
Trigger Event	Specific date for budget review or external forces requiring a review, e.g., notice of revenue shortfall and/or unforeseen rise in costs.	
Result	New budget.	
Business Process Steps	<ol style="list-style-type: none"> 1. START. Receive notice of date or other trigger event. 2. Review current budget. 3. Request information regarding cost and revenue trends, demographics, utilization, and outcomes. 4. Research national and global factors affecting revenue, costs, and benefits. 5. Convene stakeholders to consider alternatives. 6. Model various budget scenarios. 7. Build new budget. 8. Review and approve new budget. 9. END. Publish new budget. 	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

PG3 Manage FFP for MMIS

Tier 3: Manage FFP for MMIS		
Item	Details	Links
Description	<p>The Federal government allows funding for the design, development, maintenance and operation of a federally certified MMIS.</p> <p>The Manage Federal Financial Participation business process oversees reporting and monitoring of Advanced Planning Documents and other program documents necessary to secure and maintain federal financial participation.</p> <p>These are the types of functions within this business area but this does not appear to be a stand-alone process.</p>	<p>Business Process Model location: Tier 1: Program Management Tier 2: Budget</p>
Trigger Event	<p>Trigger event may include the decision to add a new program. Temporal Trigger Event which is a date or time such as a quarterly statement of expenditures.</p>	
Result	<p>State receives maximum Federal Financial Participation available for all eligible clients, systems, and administration of the MMIS.</p>	<p>1. Manage State Funds</p>
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Generate reports, e.g., CMS 64 2. Review generated reports for accuracy and deficiencies. 3. Monitor expenditures 4. Analyze potential program additions, modification, or deletions for fiscal impact 5. Finalize report 6. End: Send report via the Send Outbound Transaction process 	
Shared Data	<p>Member Registry Provider Registry Accounting Tables Payment History Repository</p>	<p>May be maintained internally or externally</p>
Predecessor	<p>Determination to add or modify a new program An established reporting time period or deadline</p>	
Successor	<p>Send reporting information via the Send Outbound Transaction process.</p>	
Constraints	<p>Manage FFP must conform to state specific reporting requirements.</p>	
Failures	<p>N/A</p>	<p>Failure Notifications</p>
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less 	

PG3 Manage F-MAP

Tier 3: Manage F-MAP		
Item	Details	Links
Description	The Manage F-MAP business process periodically assesses current F-MAP for benefits and administrative services to determine compliance with federal regulations and state objectives.	Tier 1: Program Management Tier 2: Budget
Trigger Event	Notification of need for review or receipt of an audit finding or enquiry.	
Result	Directive to revise FFP calculations; new FFP algorithms.	
Business Process Steps	<ol style="list-style-type: none"> 1. START. Receive notification of need, audit finding, or inquiry. 2. Review notification, audit finding, or inquiry. 3. Request information supporting F-MAP, FFP. 4. Review and analyze information. 5. Review applicable laws. 6. Propose change in approach to calculating F-MAP, FFP. 7. Submit change for review and approval. 8. Develop guidelines for change. 9. Develop specific algorithms. 10. Develop implementation plan. 11. END. Publish new FFP rules. 	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

PG3 Manage State Funds

Tier 3: Manage State Funds		
Item	Details	Links
Description	<p>The Manage State Funds business process oversees Medicaid state funds and ensures accuracy in reporting of funding sources.</p> <p>Funding sources for Medicaid services may come from a variety of sources and often State funds are spread across administrations. The Manage State Funds monitors state funds through ongoing tracking and reporting of expenditures.</p> <p>These are the types of functions that may occur within this business area, but this does not appear to be a stand-alone process.</p>	<p>Business Process Model location: Tier 1: Program Management Tier 1: Budget</p>
Trigger Event	<p>State-transition Trigger Event: Request from legislature or new budget approved.</p> <p>Temporal Trigger Event: Established time frame for generating quarterly reports.</p>	List business area or process that is source of trigger
Result	State is able to fund all programs without budget shortfalls.	List business area or process that is affected by the completion of the process
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Establish state and federal budget categories 2. Establish reporting requirements 3. Define report content 4. Define report frequency 5. Define report media 6. Generate report 7. End: Review reports for accuracy 	
Shared Data	<p>Member Registry Provider Registry Accounting Tables State Financial Management Applications Payment History Repository</p>	May be maintained internally or externally
Predecessor	Receive Inbound Transaction in the form of a request.	List Predecessor Processes
Successor	Sending report information via the Send Outbound Transaction .	List Successor Processes
Constraints		
Failures	N/A	Failure Notifications
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less 	

PG4 Manage 1099s

Tier 3: Manage 1099s		
Item	Details	Links
Description	<p>The Manage 1099s business process describes the process by which 1099s are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number.</p> <p>The Manage 1099s process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Manage Settlements process.</p> <p>The Manage 1099s process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the Send Outbound Transaction process. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.</p>	<p>Business Process Model location: Tier 1: Program Management Tier 2: Accounting</p>
Trigger Event	<p>Interaction Based Trigger Event: Request from a provider.</p> <p>State-transition Trigger Event: Receipt of data set from Price Claim/Value Encounter or Manage Settlements indicating payments and/or recoupments.</p> <p>Temporal Trigger Event: End of the calendar year.</p>	
Result	Updated and/or corrected 1099 forms sent to providers via the Send Outbound Transaction process.	1. Send Outbound Transaction process.
Business Process Steps	<p>Preparation/Maintenance</p> <ol style="list-style-type: none"> 1. Start: Receive claim/encounter payment and adjustment information from Price Claim/Value Encounter or Manage Settlements process. 2. Match tax ID or SS#. 3. Update cumulative totals applying all payments and recoupments including those resulting from cost settlements and manual checks. 4. Prepare 1099 at close of calendar year. 5. Send 1099 to providers prior to January 31 6. End: Submit 1099 data to Internal Revenue Service (IRS) 	

PG4 Manage 1099s

Tier 3: Manage 1099s		
Item	Details	Links
Business Process Steps (Cont'd)	<p>Additional Requests</p> <ol style="list-style-type: none"> 1. Start: Receive request for additional 1099s 2. Verify identity of requesting entity 3. Re-generate requested 1099 4. End: Send 1099 to requesting entity <p>Corrections</p> <ol style="list-style-type: none"> 1. Start: Receive notification of error. 2. Verify identity of provider 3. Research error or update request. 4. If no error found, End: Notify provider of findings 5. If error found 6. Correct system tables 7. Prepare corrected or updated 1099 8. Send corrected 1099 to affected parties. 9. End: Submit corrected 1099 data to Internal Revenue Service (IRS). 	
Shared Data	<i>Price Claim/Value Encounter</i> process. <i>Manage Settlements</i> process	List Predecessor Processes
Predecessor	<i>Send Outbound Transaction</i> <i>Manage Provider Communication</i>	List Successor Processes
Successor	Provider Registry	
Constraints	N/A	
Failures	N/A	Failure Notifications
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% Error rate = __% or less 	

PG4 Perform Accounting Functions

Tier 3: Manage F-MAP		
Item	Details	Links
Description	The Perform Accounting Functions business process monitors program expenditures and performs “draw-down” of federal matching funds as appropriate to state funds. This business process covers Medicaid administrative costs incurred by other state departments who manage Medicaid services for their populations (DEA, DCYF, BHDDH etc).	Tier 1: Program Management Tier 2: Accounting
Trigger Event	End of month accounting process to request federal matching funds.	
Result	Updated state accounting system. Federal matching funds are distributed to appropriate state accounts.	
Business Process Steps	<ol style="list-style-type: none"> 1. START. Receive certified letter from other state departments requesting federal matching funds or end of month accounting process initiates process. 2. Review expenditures input since previous cycle for accuracy. 3. Adjust fund source, FFP match to receive enhanced funding where appropriate. 4. Utilize CMS online web portal to request federal matching funds by account/program. 5. Review any errors or messages. 6. Verify funds deposited into correct account/program next business day. 7. END. Create voucher to send to State Treasury department for records. 	
Shared Data		
Predecessor		
Successor		
Constraints		
Failures		
Performance Measures		

PG5 Develop and Manage Performance Measures and Reporting

Tier 3: Develop and Manage Performance Measures and Reporting		
Item	Details	Links
Description	<p>Similar to <i>Manage Program Information</i> and <i>Generate Financial and Program Analysis/Report</i>, this business process describes how Medicaid programs create measures and reports for ongoing performance monitoring.</p> <p>The MITA Business Process Model is incomplete. This version has been created for RI.</p>	Program Management
Trigger Event	<p>Interaction based Trigger Events: This trigger event is the request that the measures/reports be produced.</p> <p>Temporal Trigger Event: The trigger event for this business process could also be based on a pre-determined time-table for scheduled report generation</p>	
Result	The financial and program analysis report is sent to the Send Outbound Transaction.	
Business Process Steps	<ol style="list-style-type: none"> 1. Define target topic (e.g., specific providers, patients, programs, etc.) 2. Define target audience (e.g., internal vs. external) 3. Define categories, measures and other report specifications 4. Define report format (e.g., tables, narrative, electronic media, etc.) 5. Define periodicity (e.g., monthly, annual, ad hoc) 6. Retrieve data from various sources 7. Compile data 8. Perform preliminary review of report output; re-compile report if required 9. Release report 10. Brief target audience (if required) 11. Review, refine, repeat (if periodic) 	
Shared Data	<p>Member Registry Provider Registry Benefits/Reference Repository Claims / Encounter History</p>	
Predecessor	Performance measures and reports produced using data from <i>Manage Program Information.</i>	
Successor	Send Outbound Transaction.	
Constraints	The generation of performance measures and reports must adhere to state specific laws, regulations, and requirements. These rules will differ by state.	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: e.g., Real Time response within __ seconds, Batch Response within __ hours 2. Accuracy of decisions 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less 	

PG6 Generate Financial & Program Analysis/Report

Tier 3: Generate Financial & Program Analysis/Report		
Item	Details	Links
Description	<p>It is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established are meeting the needs of the member population and are performing according to the intent of the legislative laws or Federal reporting requirements.</p> <p>The Generate Financial & Program Analysis/Report process begins with a request for information or a time table for scheduled correspondence. The process includes defining the required reports format, content, frequency and media, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy), retrieving data from multiple sources, e.g., Manage Payment History, Maintain Member Information, Manage Provider Information, and Maintain Benefits/Reference Repository; compiling the retrieved data, compiling the data, and formatting into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction.</p> <p>NOTE: This process does not include maintaining the benefits, reference, or program information. Maintenance of the benefits and reference information is covered under a separate business process.</p>	<p>Business Process Model location</p> <p>Tier 1: Program Management</p> <p>Tier 2: Program Information</p>
Trigger Event	<p>Interaction based Trigger Events: This trigger event is the request that financial and/or reporting information be produced.</p> <p>Temporal Trigger Event: The trigger event for this business process could also be based on a pre-determined time-table for scheduled report generation</p>	
Result	<p>The financial and program analysis report is sent to the Send Outbound Transaction.</p>	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Define required report(s) format, content, frequency, and media for the reports 2. Define state and federal budget categories of service, eligibility codes, provider type and specialty codes (taxonomy codes), accounting codes and other codes necessary to produce the reports 3. Retrieve data from multiple sources, e.g., claims payment history data, member eligibility data, provider data, and program and benefit data 4. Compile the data into the defined format 5. Format the data 6. End: <ol style="list-style-type: none"> a. end data set to the Send Outbound Transaction for generation into an outbound transaction. 	

PG6 Generate Financial & Program Analysis/Report

Tier 3: Generate Financial & Program Analysis/Report		
Item	Details	Links
Shared Data	Member Registry Provider Registry Benefits/Reference Repository Payment History	
Predecessor	Request for financial and/or reporting data/information be produced using data from Manage Payment History ; Maintain Member Information ; Manage Provider Information ; and Maintain Benefits/Reference Repository .	
Successor	Send Outbound Transaction.	
Constraints	The generation of financial and program analysis reports must adhere to state specific laws, regulations, and requirements. These rules will differ by state.	
Failures	N/A	
Performance Measures	<ol style="list-style-type: none"> 1. = ___% Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Accuracy of decisions 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less 	

PG6 Maintain Benefits/Reference Information

Tier 3: Maintain Benefits/Reference Information		
Item	Details	Links
Description	The Maintain Benefits/Reference Information process is triggered by any addition or adjustment that is referenced or used during the Edit Claim/Encounter, Audit Claim/Encounter or Price Claim/Encounter . It can also be triggered by the addition of a new program or the change to an existing program due to the passage of new state or federal legislation, or budgetary changes. The process includes adding new HCPCS, CPT and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the Manage Prospective & Current Member Communication , updating/adding provider information from the Manage Provider Information , adding/adding drug formulary information, and updating/adding benefit packages under which the services are available from the Receive Inbound Transaction .	Business Process Model Location: Tier 1: Program Management Tier 2: Program Information
Trigger Event	Interaction-based Trigger Event: The maintain benefits/reference repository is triggered by the Receive Inbound Transaction .	
Result	Payment of claims during Edit Claim/Encounter, Audit Claim/Encounter or Price Claim Encounter .	Links to other E2E threads: Edit Claims/Encounter; Audit Claims/Encounter; Price Claims/Encounter
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Add new codes and rates 2. Update rates 3. Update/add member benefits 4. Update/add provider information 5. Update/add drug formulary information 6. End: Update/add program under which services are available. 	
Shared Data	Rate data Member benefits data Provider data Program data	May be maintained internally or externally
Predecessor	Receive Inbound Transaction .	
Successor	Edit Claim/Encounter, Audit Claim/Encounter or Price Claim Encounter	
Constraints	The Benefits/Reference Repository must be maintained according to state specific policies and procedures that may differ by state.	
Failures	N/A	

PG6 Maintain Benefits/Reference Information

Tier 3: Maintain Benefits/Reference Information		
Item	Details	Links
Performance Measures	<ol style="list-style-type: none">1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ days2. Accuracy of decisions = ___%3. Consistency of decisions.4. Error rate = __% or less.	

PG6 Manage Program Information

Tier 3: Manage Program Information		
Item	Details	Links
Description	<p>The Manage Program Information business process is responsible for managing all the operational aspects of the Program Information Repository, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions.</p> <p>The Program Information Repository receives requests to add, delete, or change data in program records. The Repository validates data upload requests, applies instructions, and tracks activity.</p> <p>The Program Information Repository provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, via batch record transfers, response to queries, and “publish and subscribe” services.</p>	<p>Business Process Model location: Tier 1: Program Management Tier 2: Program Information</p>
Trigger Event	<p>State-transition Trigger Event: Program Information Repository receives data to be loaded as initial records or updates to data in existing records from any Business Area</p> <ol style="list-style-type: none"> 1. State transition trigger event: Receipt of request to add, delete, change Program information from Member, Provider, and Contractor Registries, and the Payment, Care and Program Integrity Management Repositories 2. Interaction-based Trigger Event: Receipt of a query about data in one or more program records from enterprise business processes, or from authorized external parties, e.g., a legislator requests outcome measures for a particular program. 3. Environmental Trigger Event: Scheduled transmission of program information records or pointers to program information on a periodic or real time basis to authorized external parties, e.g., CMS MSIS. 	<p>Links to other processes: All Manage Information business processes; all other Program Management business processes</p>

PG6 Manage Program Information

Tier 3: Manage Program Information		
Item	Details	Links
Result	<p>The Program Information Repository is loaded with new or updated data from all Business Areas and made available to all Business Area processes as required for analysis, reporting, and decision reporting; including:</p> <ol style="list-style-type: none"> 1. Responding to queries from authorized users and applications 2. Supplying all other Program Management Area business processes with program information as needed to, e.g., develop benefit packages and drug formularies, set rates, analyze and project budgets, perform accounting functions, manage FFP, measure quality, outcomes and performance; and develop policies and strategic initiatives, etc. 3. Supplies all Business Area processes with program information needed to e.g., manage communications, manage business relationships, perform outreach and education, manage contracts, etc. 4. Sends records or pointers to external parties for reporting, e.g., CMS MSIS and public health for population health studies 	<p>Links to other processes: All business processes</p>
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Load initial data from enterprise information registries or repositories 2. Loads data into the Program Information Repository, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Process the records so that the data is available as required, e.g., to an operational data store, a data mart, or a data warehouse 4. Provide reporting, analysis and decision support capabilities 5. Manage versioning issues 6. Provides access to records as requested by authorized business processes and users, e.g., Manage Business Relationships and Program Integrity Identify Case processes 7. End: Archive data in accordance with state and federal record retention requirements 	<p>Each state will specify its data requirements and rules for each step</p>
Shared Data	<p>Member, provider, contractor, payment, operations, program, program integrity, business relationship and care management information</p>	
Predecessor	<p>Manage Member, Provider, Contractor, Business Relationship, Operations, Program, Program Integrity and Care Management information</p>	
Successor	<p>All business processes requiring access to program information.</p>	
Constraints	<p>Policies and procedures will differ by state, especially those relating to data standards, record keeping, and privacy.</p>	

PG6 Manage Program Information

Tier 3: Manage Program Information		
Item	Details	Links
Failures	Inability or failure to load initial records or update data in existing records in the Program Information Repository	
Performance Measures	<ol style="list-style-type: none">1. Time to complete Enrollment process = within __ days2. Accuracy with which edits are applied = ___%3. Consistency of decisions = ___%4. Error rate = __% or less	

Provider Management

PM Enroll Provider

Tier 3: Enroll Provider		
Item	Details	Links
Description	<p>The Enroll Provider business process is responsible for managing providers' enrollment in programs, including</p> <ul style="list-style-type: none"> ■ Receipt of enrollment application data set from the Manage Provider Communication process ■ Processing of applications, including status tracking (e.g., new, resubmission, duplicate) and validating application meets state submission rules, e.g., syntax/semantic conformance ■ Validation that the enrollment meets state rules by <ul style="list-style-type: none"> – Performing primary source verification of verifies provider credentials and sanction status with external entities, including: <ul style="list-style-type: none"> • Education and training/Board certification • License to practice • DEA/CDS Certificates • Medicare/Medicaid sanctions • Disciplinary/sanctions against licensure • Malpractice claims history • NPDB and HIPDB disciplinary actions/sanctions – Verifying or applying for NPI enumeration with the NPPES – Verifying SSN or EIN and other business information ■ Determine contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill ■ Establish payment rates and funding sources, taking into consideration service area, incentives or discounts ■ Negotiate contracts ■ Supporting receipt and verification of program contractor's provider enrollment roster information, e.g., from MCO and HCBS organizations ■ Requesting that the Manage Provider Information process load initial and changed enrollment information, including providers contracted with program contractors into the Provider Registry 	<p>Business Process Model location: Business Area: Provider Management; Tier 2: Provider Enrollment</p>

PM Enroll Provider

Tier 3: Enroll Provider		
Item	Details	Links
Description (Cont'd)	<ul style="list-style-type: none"> ■ Prompting the Manage Provider Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including: <ul style="list-style-type: none"> - The Capitation and Premium Payment Area - The Prepare Provider EFT/Check process - The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights ■ Perform scheduled user requested: <ul style="list-style-type: none"> - Credentialing reverification - Sanction monitoring - Payment rate negotiations - Performance evaluation <p>External contractors such as quality assurance and credentialing verification services may perform some of these steps</p>	
Trigger Event	<p>State-transition Trigger Events: Receipt of the following from either the provider or external contractor via the Receive Inbound Transaction process or from the Manage Provider Communication process:</p> <ul style="list-style-type: none"> ■ Enrollment application data set containing Provider Name, Provider Address, Provider Affiliation, Provider SSN or EIN, Provider Type, Specialty, Taxonomy, Allowed Services, Provider Credentials or Licenses, etc. ■ Resubmitted enrollment application data set ■ Modification or cancellation of an application data set ■ Additional information in support of an enrollment application <p>Environmental Trigger Event: Receipt of scheduled prompt of user request to</p> <ul style="list-style-type: none"> ■ Reverify credentials ■ Monitor sanctions ■ Assist in program integrity review ■ Renegotiate payment rates ■ Reevaluate enrollment based on, e.g., performance measures 	<p>Links to other processes: Receive Inbound Transaction Manage Provider Communication Benefit Administration Area processes Program Quality Management Area processes Program Integrity Area processes</p>

PM Enroll Provider

Tier 3: Enroll Provider		
Item	Details	Links
Result	<ol style="list-style-type: none"> 1. Provider is either enrolled, re-enrolled, or denied enrollment 2. The Provider Registry is updated, enrollment data required for operations is made available, and alerts are broadcast to subscribing processes such as the Capitation and Premium Payment Area business processes, and the Prepare Provider EFT/Check, the Perform Provider Outreach and Education, and the Communications processes 3. The Provider is notified about enrollment results 4. Operations Management Area processes reflect changes 	Links to other processes: Manage Provider Information Manage Provider Communication
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive enrollment application and other pertinent enrollment communication data set, or prompt for re-verification of currently enrolled provider 2. Validate application syntax/semantic conformance. [If validation fails, process terminates – see Failures.] 3. Determine submission status by querying the Provider Registry. Application status may be initial, resubmitted with modification, or duplicate. [If resubmit, message will contain only updated data and some steps below may be skipped; if duplicate, process terminates and result messages are produced – see Failures.] Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 4. Re-verification requires accessing provider enrollment record from the Provider Registry and completing steps as appropriate 5. Determine applicant type/provider taxonomy: e.g., Primary, Rendering, Pay To, Billing, Other 6. Verify information in the enrollment application or record with internal and external sources, including <ol style="list-style-type: none"> a. Enumerators, including NPI, SSN, EIN, internal enumerators. If lacking, facilitate enumeration b. Sanction status, e.g., HIPDB, NPDB, Boards, criminal background checks; and provider performance profiles c. Credentials, e.g., licensure, specialty boards, and school, affiliations <p>Verify with external entities by sending inquiry data sets via Send Outbound Transaction and evaluating response data sets received from the Receive Inbound Transaction process. Verify with internal sources via services, interfaces, or manually</p> 	Each state will specify its data requirements and rules for each step

PM Enroll Provider

Tier 3: Enroll Provider		
Item	Details	Links
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 7. Determine contracting parameters, e.g., provider taxonomy, categories of service for which the provider can bill, eligible provider types, payment types, contract terms and maximums, client enrollment levels, panel size, and any contractor specific benefit packages and procedures 8. Assign any identifiers used internally 9. Assign to programs and determine rates: Includes identifying type of rate, e.g., Negotiated, Medicare, Percent of Charges, Case Management fee, Other via look-ups in the Reference and Benefit Repositories 10. Request that the Manage Provider Communication process negotiate contract and send enrollment determination notifications 11. Request that the Perform Provider Outreach and Education process send relevant state policy information 12. End: Produce enrollment record data set for loading into the Provider Registry and request that the Manage Provider Information process load the information 	
Shared Data	<ol style="list-style-type: none"> 1. Provider Registry data: e.g., NPI, provider demographics, provider taxonomy 2. NPI and provider demographics exchanged with the National Plan and Provider Enumeration System (NPDES) 3. Provider sanction data from: <ol style="list-style-type: none"> a. OIG/GAO sanction lists of individuals, vendors, and/or suppliers that are excluded from participation in Medicare, Medicaid and other federally funded state programs b. State Provider Licensing Authority c. HIPDB Repository d. NPDB Repository 4. Tax identifiers: EIN, SSN, TIN from applicant and verified with tax identifier verification sources 5. Multiple office locations, pay to addresses, business associates and key contract personnel 6. MCO and program contracted provider information including demographics, enumerations, business, and credentialing verification 	

PM Enroll Provider

Tier 3: Enroll Provider		
Item	Details	Links
Predecessor	<ul style="list-style-type: none"> ■ The Receive Inbound Transaction authenticates submitter, verifies application format, may translate, may scan, logs in request, and produces the enrollment application message which is sent to the Enroll Provider process. ■ The Manage Provider Communication process may send inquiries about the enrollment process or prompts to re-verify provider ■ The Monitor Performance and Business Activity process may send prompts to reevaluate provider enrollment ■ The Program Integrity Area processes may request enrollment review activities 	Receive Inbound Transaction, Manage Provider Communication, Monitor Performance and Business Activity
Successor	<ol style="list-style-type: none"> 1. Manage Provider Communication process 2. Monitor Performance and Business Activity process 3. Manage Provider Information process 4. Operations Management Area business processes 5. Send Outbound Transaction process 6. Receive Inbound Transaction process 	Manage Provider Communication, Manage Provider Information, Send Outbound Transaction, Receive Inbound Transaction
Constraints	The Provider application and enrollment process must accommodate the full range of provider types, organizations, specialties, different types of applicants (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., solo office practice, group practice, Rural Health Clinic); as well as different types of application, e.g., New, Modification, Cancellation, Update. Different business logic will apply to each of these different types.	Business logic differences for type
Failures	<p>Process Failure: Enrollment application processing terminates or suspends due to:</p> <ol style="list-style-type: none"> 1. Duplicate or cancelled applications 2. Failure to validate application edits 3. Requires additional information to process application 4. The Manage Provider Communication and Perform Provider Outreach and Education processes fail to send, e.g., notification of application processing issues, enrollment decision outcomes, and procedural rights, or materials about state policies related to provider enrollment 	Result messages

PM Enroll Provider

Tier 3: Enroll Provider		
Item	Details	Links
Failures (Cont'd)	<p>Alternate Process Path: Enrollment process results in a denial or delay of an enrollment requests for reasons such as:</p> <ol style="list-style-type: none"> 1. Provider fails to meet state enrollment requirements 2. Provider fails enumeration or credentialing verification 3. Provider cannot be enumerated through NPPES or state assigned enumerator 4. Lack of applicable rates 5. Inability to negotiate rates or contract <p>This process requests that the Manage Provider Communication process prepare application rejection or failure notifications, or requests for additional information data sets for generation and transmission by the Send Outbound Transaction process</p>	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less 	
Provider Enrollment Variations		
Type	Subtypes	Data
Institutional Provider	<p>The Institutional Provider application must accommodate a range of institutional provider types (e.g., Inpatient, Nursing Home, Day Care), different types of applicants (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., Outpatient, Emergency Room, Assisted Living)</p>	<p>Type of Facility, Bed Size, Taxonomy, Type of Institutional Services, Ownership, Tax Code, DRG or other payment type</p>
Professional Provider	<p>The Professional Provider application must accommodate a range of professional provider types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, Other), different types of applicants (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., solo office practice, group practice, Rural Health Clinic).</p> <p>Enumerate a Group Health Practice separately from the individual physicians associated with it.</p>	<p>Provider Type, Affiliation, Location</p>
Pharmacy	<p>The Pharmacy application must accommodate a range of types (e.g., major chain with hundreds of stores, community pharmacy), different types of applicants (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., retail store, outpatient facility, nursing home).</p> <p>The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.</p>	<p>Type, ownership, location, unit dose, mail order, DUR compliance</p>

PM Enroll Provider

Tier 3: Enroll Provider		
Item	Details	Links
A-Typical	<p>The A-typical provider application must accommodate a range of types of programs (e.g., Waiver, assistance in the home), different kinds of service providers (e.g., family caretaker, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., in the home, day care center).</p> <p>The NPI enumeration will not provide ID numbers for A-typical providers at this time.</p>	Type of service provider, allowed services, invoicing method

PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	Details	Links
Description	<p>The Disenroll Provider business process is responsible for managing providers' enrollment in programs, including:</p> <ul style="list-style-type: none"> ■ Processing of disenrollment <ul style="list-style-type: none"> – Requested by the provider – Requested by another Business Area, e.g., the Manage Provider Communication, Monitor Performance and Business Activities, and Program Integrity Manage Case processes – Due to receipt of information about a provider's death, retirement, or disability from the Manage Provider Communication process – Based on failure in the Enroll Provider process, e.g., Provider fails to meet state enrollment requirements <ul style="list-style-type: none"> • Provider fails enumeration or credentialing verification • Provider cannot be enumerated through NPPES or state assigned enumerator • Lack of applicable rates • Inability to negotiate rates or contract ■ Tracking of disenrollment requests and records, including assigning identifiers and monitoring status (e.g., new, resubmission, duplicate) ■ Validation that the disenrollment meets state rules and substantiating basis for disenrollment, e.g., checking death records ■ Requesting that the Manage Provider Information process load initial and changed disenrollment information into the Provider Registry ■ Prompting the Manage Provider Communication process to prepare disenrollment notifications and instructions for closing out provider contracts for generation and transmission by the Send Outbound Transaction process ■ Prompting the Manage Provider Information process to provide timely and accurate notification or to make disenrollment data required for operations available to all parties and affiliated business processes, including <ul style="list-style-type: none"> – The Capitation and Premium Payment Area – The Prepare Provider EFT/Check process 	<p>Business Process Model location: Business Area: Provider Management; Tier 2: Provider Enrollment</p>
Description (Cont'd)	<ul style="list-style-type: none"> ■ Prompting Manage Applicant and Member Communication process to notify and reassign, where necessary, members who are on the provider's patient panel, e.g., PCCM, Lock-in, HCBS and other waiver program, and FFS ■ Prompting Perform Applicant and Member Outreach to provide appropriate outreach and educational material to displaced members 	

PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	Details	Links
Trigger Event	<p>State-transition Trigger Event:</p> <ul style="list-style-type: none"> ■ Receipt of information relating to failed enrollment applications from the Enroll Provider process <p>Interaction based Trigger Event:</p> <ul style="list-style-type: none"> ■ Receipt of a disenrollment request or a modification of or cancellation of a request either directly, from the Manage Provider Communication process, or from another Business Area, e.g., Monitor Performance and Business Activity or Program Integrity Manage Case processes 	<p>Links to other processes:</p> <p>Receive Inbound Transaction</p> <p>Enroll Provider</p> <p>Manage Provider Communication</p> <p>Program Quality Management Area</p> <p>Program Integrity Area</p>
Result	<ol style="list-style-type: none"> 1. Provider is disenrolled 2. The Provider Registry is updated, disenrollment data required for operations is made available, and alerts are broadcast to subscribing processes such as the Monitor Performance and Business Activity, Care Management Area, Program Integrity Area, Capitation and Premium Payment Area, and the Prepare Provider EFT/Check, and the Communications processes 3. The Provider and/or affected parties are notified by the Communications processes about the disenrollment, e.g., in the case of fraud and abuse, Medicare/Medicaid Sanction, NPDB, HIPDB, and state licensing boards; and members on the provider’s patient panel, who may be reassigned if appropriate 4. Provider contract is terminated and closed out 5. Operations Management Area reflect changes 	<p>Links to other processes:</p> <p>Manage Provider Information</p> <p>Manage Provider Communication Operations Management Area</p>
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive disenrollment request or relevant information 2. Assign unique identifier for tracking 3. Validate application syntax/semantic conformance 	<p>Each state will specify its data requirements and rules for each step</p>

PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	Details	Links
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 4. Determine disenrollment request or information processing status by querying the Provider Registry; status may be initial, resubmitted with modification, or duplicate [If resubmit, message will contain only updated data and some steps below may be skipped; if duplicate, process terminates and result messages are produced – see Failures.] Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 5. Verify the disenrollment information 6. Validate that the disenrollment request meets state rules 7. Produce disenrollment record data set and request that the Manage Provider Information process load disenrollment record into the Provider Registry 8. Request that the Manage Provider Communication prepare disenrollment notification for the Outbound Transaction process to generate and send to the provider including notification of appeal rights 9. Request that the Perform Provider Outreach and Education process send relevant state policy information 10. End: Alert the Operations and Program Management Area that new or updated disenrollment information has been loaded into the Provider Registry 	
Shared Data	<ol style="list-style-type: none"> 1. Provider Registry data: e.g., NPI, provider demographics, provider taxonomy 2. NPI and provider demographics exchanged with the National Plan and Provider Enumeration System (NPDES) 3. Provider sanction data from: <ol style="list-style-type: none"> a. OIG/GAO sanction lists of individuals, vendors, and/or suppliers that are excluded from participation in Medicare, Medicaid and other federally funded state programs b. State Provider Licensing Authority c. HIPDB Repository d. NPDB Repository 4. Tax identifiers: EIN, SSN, TIN from applicant and verified with tax identifier verification sources 	
Predecessor	<ul style="list-style-type: none"> ■ The Receive Inbound Transaction authenticates submitter, verifies application format, may translate, may scan, logs in request, and produces the disenrollment request or disenrollment information message which is sent to the Enroll Provider process ■ The Manage Provider Communication process may send requests, inquiries or information about disenrollment ■ The Monitor Performance and Business Activity process may send requests to terminate provider enrollment ■ The Program Integrity Area may request enrollment review activities 	Receive Inbound Transaction, Manage Provider Communication, Monitor Performance and Business Activity

PM Disenroll Provider

Tier 3: Disenroll Provider		
Item	Details	Links
Successor	<ol style="list-style-type: none"> 1. Manage Provider Communication process 2. Monitor Performance and Business Activity process 3. Manage Provider Information process 4. Program Integrity Area 5. Operations Management Area 6. Send Outbound Transaction process 7. Receive Inbound Transaction process 	Manage Provider Communication, Manage Provider Information, Send Outbound Transaction, Receive Inbound Transaction
Constraints	The Provider disenrollment process must accommodate the full range of provider types, organizations, specialties, different types of applicants (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., solo office practice, group practice, Rural Health Clinic); as well as different types of application, e.g., New, Modification, Cancellation, Update. Different business logic will apply to each of these different types.	Business logic differences for type
Failures	<p>Process Failure: Enrollment application processing terminates or suspends due to:</p> <ol style="list-style-type: none"> 1. Duplicate or cancelled disenrollment requests 2. Failure to validate requests 3. Failure to verify information that is grounds for disenrollment 4. Disenrollment fails to meet state rules 5. Provider successfully appeals disenrollment 6. Requires additional information to process disenrollment 	Result messages
Failures (Cont'd)	<ol style="list-style-type: none"> 7. The Manage Provider Communication and Perform Provider Outreach and Education processes fail to send, e.g., notification of disenrollment outcomes, including either the approval or the dismissal of request, or a successful provider appeal; procedural rights; or materials about state policies related to provider enrollment <p>Alternate Process Path: Provider continues to be enrolled because the information upon which disenrollment would be based proves untrue, e.g., provider is not deceased; or the disenrollment request does not meet state rules</p>	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete Enrollment process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less 	

PM Inquire Provider Information

Tier 3: Inquire Provider Information		
Item	Details	Links
Description	The <i>Inquire Provider Information</i> business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the <i>Send Outbound Transaction</i> process.	Business Area: Provider Management; Tier 2: Provider Information Management
Trigger Event	Interaction-based Trigger Event: Receipt of provider enrollment verification request data set from <i>Receive Inbound Transaction</i> process.	Receive Inbound Transaction
Result	<ol style="list-style-type: none"> 1. Provider enrollment verification response data set routed to <i>Send Outbound Transaction</i> process. Data set may include information such as enrollment start/end dates, provider type and specific specialties. 2. Tracking information regarding the interchange as needed for the <i>Inquire Provider Information</i> process for measuring performance and business activity monitoring. 	Send Outbound Transaction
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receipt of provider verification information data set from <i>Receive Inbound Transaction</i> Process. 2. Determine Request status as initial or duplicate. 3. Verify authorization of the requester to receive requested information. 4. Query Provider Registry for requested information 5. Process Response 6. Log Response 7. End: Prepare response data set for the <i>Send Outbound Transaction</i> process 	
Shared Data	Provider Registry	
Predecessor	<i>Receive Inbound Transaction</i> process	
Successor	<i>Send Outbound Transaction</i> process	
Constraints	States determine what information can be shared and who can access requested information.	
Failures	<ol style="list-style-type: none"> 1. Process unable to process the provider information verification request. 2. Requester not authorized to receive requested information. 	
Performance Measures	<ol style="list-style-type: none"> 1. Time to verify provider information and generate response data set: e.g., Real Time response = within __ seconds, Batch Response = within __ hours 2. Response Accuracy = __% 3. Error rate = __% or less 	

PM Manage Provider Communication

Tier 3: Manage Provider Communication		
Item	Details	Links
Description	<p>The Manage Provider Communication business process receives requests for information, provider publications, and assistance from prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via Send Outbound Transaction process.</p> <p>Note: Inquires from prospective and current providers are handled by the Manage Provider Communication process by providing assistance and responses to <u>individual entities</u>, i.e., bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The Perform Provider Outreach process targets both prospective and current provider <u>populations</u> for distribution of information about programs, policies, and health care issues.</p>	<p>Business Area: Tier 1: Provider Management; Tier 2: Provider Support</p>
Trigger Event	<p>Interaction-based Trigger Event:</p> <ol style="list-style-type: none"> 1. Inquiry from current or prospective provider. 2. Request to send information packages such as provider enrollment applications and/or billing instructions. 3. Request for assistance, such as a request for training or change in provider information. 4. Requests from other processes to develop and produce communications for providers such as notifications from the Enroll Provider process such as requests for additional information, new provider information packages. <p>Temporal Trigger Event: Scheduled time to send information, e.g., within 24 hours of new provider enrollment; notification of pending expired provider eligibility, and monthly communications such as provider newsletters or other agency communications.</p>	
Result	<ol style="list-style-type: none"> 1. Provider receives appropriate assistance, communications, and/or information packages. 2. Tracking information regarding the interchange as needed for the Manage Provider Communication process to ensure prospective and current providers receive the information they need. 	<p>Send Outbound Transaction</p>

PM Manage Provider Communication

Tier 3: Manage Provider Communication		
Item	Details	Links
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive request for communication from Receive Inbound Transaction process or from other processes such as Manage Provider Grievance and Appeal to prepare communications 2. Log and track communications request and response processing data 3. Research/develop communication that is linguistically, culturally, and competency appropriate 4. Prepare/package communication. 5. End: Send provider communications and information packages to be distributed by the Send Outbound Transaction process. 	
Shared Data	<ol style="list-style-type: none"> 1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Contractor Registry: Contracted service areas, MCO provider network and other provider data 3. Provider Registry: Provider data, such as type, location, availability. 	
Predecessor	<ol style="list-style-type: none"> 1. Receive Inbound Transaction 2. Enroll Provider 3. Manage Provider Grievances and Appeals 	Links to processes: <ol style="list-style-type: none"> 1. Receive Inbound Transaction 2. Enroll Provider 3. Manage Provider Grievances and Appeals
Successor	Send Outbound Transaction process	Send Outbound Transactions
Constraints	Communications requested will vary by state, depending on programs supported and type of provider requesting information.	
Failures	<ol style="list-style-type: none"> 1. Inability to provide linguistically, culturally, or competency appropriate information 2. Communication barriers such as lack of Internet or failure to access needed or requested information 3. Delivery failures due to erroneous contact information or lack of contact information. 	
Performance Measures	Examples of Measures – <ol style="list-style-type: none"> 1. Time to complete process of developing communications: By phone __ minutes; by email ___ hours; by mail __ days 2. Accuracy of communications = __% 3. Successful delivery rate to targeted providers = ___% 	

PM Manage Provider Grievance and Appeal

Tier 3: Manage Provider Grievance and Appeal		
Item	Details	Links
Description	<p>The Manage Provider Grievance and Appeal business process handles provider* appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process.</p> <p>This process supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.</p> <p>NOTE: States may define “grievance” and “appeal” differently, depending on state laws.</p> <p>*This process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when an application for enrollment is denied.</p>	Business Area: Provider Management; Tier 2: Provider Support
Trigger Event	Receipt of grievance or appeal of adverse decision data set from Receive Inbound Transaction process.	Receive Inbound Transaction
Result	Final disposition of grievance or appeal sent to the applicant or member via the Send Outbound Transaction process.	Send Outbound Transaction
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive grievance or appeal via Receive Inbound Transaction Process 2. Situational: Request additional documentation 3. Determine status as initial, second, or expedited. 4. Triage to appropriate personnel for review. 5. Perform research and analysis 6. Schedule hearing within required time. 	
Business Process Steps (Cont'd)	<ol style="list-style-type: none"> 7. Conduct hearing within required time. 8. Determine disposition. 9. End: Request that the Manage Applicant and Member Communication process prepare a formal disposition to be sent to the provider via Send Outbound Transaction process. <p>NOTE: Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.</p>	

PM Manage Provider Grievance and Appeal

Tier 3: Manage Provider Grievance and Appeal		
Item	Details	Links
Shared Data	<ol style="list-style-type: none"> 1. Benefit Repository: Services and provider types covered; program policy; and health plan contractor information 2. Contractor Registry: Contracted service areas, MCO provider network and other provider data 3. Provider Registry: Provider data, such as type, location, availability. 4. Grievance and Appeal Case File Repository 	
Predecessor	Receipt of appeal data set from Receive Inbound Transaction process.	Receive Inbound Transaction
Successor	Formally notify applicant or member via Send Outbound Transaction process.	Send Outbound Transaction
Constraints	States have different requirements for evidence and the process for conducting the grievance/appeals cases. They have different rules for assigning outcome status and state-specific consequences.	
Failures	N/A	
Performance Measures	<p>Examples of Measures –</p> <ol style="list-style-type: none"> 1. Time to complete process: normal grievance/appeal = __days; second appeal = __days; expedited appeal = __hours 2. Accuracy of decisions = __% 3. Consistency of decisions and disposition = __% 	

PM Manage Provider Information

Tier 3: Manage Provider Information		
Item	Details	Links
Description	<p>The Manage Provider Information business process is responsible for managing all operational aspects of the Provider Registry, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the state Medicaid.</p> <p>The Provider Registry is the Medicaid enterprise “source of truth” for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The Registry includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services.</p> <p>In addition, the Provider Registry stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and all communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal.</p> <p>The Provider Registry may store records or pointers to records for services requested and services provided; performance, utilization, and program integrity reviews; and participation in member care management.</p> <p>Business processes that generate prospective or contracted provider information send requests to the Member Registry to add, delete, or change this information in registry records. The Provider Registry validates data upload requests, applies instructions, and tracks activity.</p> <p>The Provider Registry provides access to member records to applications and users via batch record transfers, responses to queries, and “publish and subscribe” services.</p> <p>Among the business processes that will interface with the Provider Registry are</p> <ul style="list-style-type: none"> ■ The Enroll and Disenroll Provider processes, which send and retrieve provider information relating to these processes such as application, credentialing and enumeration review status ■ The Provider Support processes, such as Manage Provider Communication ■ All Operations Management business processes, e.g., Edit Claim/Encounter, Apply Mass Adjustment, Authorize Service, and Prepare Provider EFT/Check ■ The Maintain Benefit/Reference Information process, which is the Provider Registry’s source of benefit package information 	<p>Business Process Model location: Business Area: Tier 1: Provider Management; Tier 2: Provider Information Maintenance</p>

PM Manage Provider Information

Tier 3: Manage Provider Information		
Item	Details	Links
Description (Cont'd)	<ul style="list-style-type: none"> ■ Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Provider Registry for provider information ■ Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Provider Registry 	
Trigger Event	<ol style="list-style-type: none"> 1. State transition trigger event: Receipt of request to add, delete, change Provider information or pointers to provider information records from <ol style="list-style-type: none"> a. Provider Management Business Area processes: Enroll and Disenroll Provider, Perform Provider Outreach and Education, Manage Applicant and Member Communication, or Manage Applicant and Member Grievance and Appeal b. The Maintain Benefit/Reference Information process, which is the Provider Registry's source of benefit package information that may be changed during the provider's contract c. Operations Management Business Area processes: Manage Payment Information (e.g., claims/encounters, COB, TPL, cost recoveries, HIPP, and service authorization) d. Care and Program Integrity Management Manage Repository processes 2. Interaction-based Trigger Event: Receipt of a query about data in one or more prospective or contracted provider records from enterprise business processes, or from authorized external parties, e.g., for verification of provider information. 3. Environmental Trigger Event: Scheduled transmission of provider information records or pointers to provider information on a periodic or real time basis to the Manage Program Information business process 	
Result	<p>The Provider Registry is loaded with new or updated provider information for the purposes of:</p> <ol style="list-style-type: none"> 1. Responding to queries from authorized users and applications 	

PM Manage Provider Information

Tier 3: Manage Provider Information		
Item	Details	Links
Result (Cont'd)	<ol style="list-style-type: none"> 2. Supplying all Provider Management Area business processes with prospective or contracted provider information as needed to, e.g., detect duplicate applications; schedule recertification, performance and contract review; perform provider outreach and communication functions, etc. 3. Supplying all Operations Management Area business processes with contracted provider information needed to, e.g., edit claims and encounters, prepare remittance advice/encounter report and provider EFT/check, etc. 4. Sending records or pointers to the Manage Program Information business process 	
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receives data from Provider Management Area and relevant Operations Management business processes 2. Loads data into the Provider Registry, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Provides access to records as required by Provider Management Area business processes workflow 4. Provides access to records as requested by other authorized business processes and users 5. Provides data to the Manage Program Information business process on a real time or periodic basis in update or snapshot mode 6. End: Archive data in accordance with state and federal record retention requirements 	Each state will specify its data requirements and rules for each step
Shared Data	Data needed to record information about the following: Provider demographic; business identifier, contact, and address; credentialing, enumeration, performance profiles; payment processing, and tax information contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services.	
Predecessor	<p>Inbound Transaction processing of provider enrollment applications, communications, scheduling requests, etc.</p> <p>Provider Management Area business processes supplying data to the Provider Registry, including Enroll and Disenroll Provider, Provider Outreach and Education, Manage Provider Communication, and Manage Provider Grievance and Appeal.</p> <p>Operations Management business processes supplying data to the Provider Registry including Prepare Remittance Advice/Encounter Report and Provider EFT/Check business processes.</p>	

PM Manage Provider Information

Tier 3: Manage Provider Information		
Item	Details	Links
Successor	<p>Outbound Transaction Processing for provider enrollment applications, communications, scheduling requests, etc. Provider Management business processes accessing data in the Provider Registry, including Enroll and Disenroll Provider, Perform Provider Outreach and Education, Manage Provider Communication, and Manage Provider Grievance and Appeal.</p> <p>Operations Management Area business processes, including Edit and Audit Claims and Encounters business processes; Prepare Capitation Payment (PCCM); Service Authorization, and all Cost Recovery business processes. Manage Program Information business process</p> <p>The following processes may need to access provider data from the Member Registry rather than from the Program Information Repository:</p> <ul style="list-style-type: none"> ■ Care Management Establish and Manage Case business processes ■ Program Integrity Identify and Establish Case business processes 	
Constraints	State specific work flows will determine which processes load and access the Provider Registry and by which interactions and messages (e.g., query/response, batch uploads, publish and subscribe, etc.); and the data content and structure of registry records	
Failures	Provider Registry fails to load or update appropriately; or fails to make registry data available or available in correct format.	
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ days 2. Accuracy of decisions = ___% 3. Consistency of decisions. 4. Error rate = __% or less. 	

State Specific

PM State-Specific Provider Enrollment Certification

Tier 3: Provider Enrollment Certification		
Item	Details	Links
Description	<p>The Provider Enrollment Certification business process is responsible for certifying Medicaid providers in the following programs prior to applying to become a Medicaid provider.</p> <ul style="list-style-type: none"> ■ Shared Living ■ Comprehensive Evaluation Diagnosis Assessment Referral and Reevaluation (CEDARR) Family Centers ■ Respite ■ Personal Assistance Services and Support (PASS) ■ Home Based Therapeutic Services (HBTS) ■ Kid Connect Day Care ■ Lead Center ■ Fiscal Agents for LTC case management ■ Local Education Agencies (school departments must sign an Interagency Agreement with the DHS prior to applying to become a Medical Assistance Provider) <p>Providers for each program must meet program specific certification criteria before certification is granted. Once deemed “certified”, the provider must apply to become a Medicaid provider following the Enroll Standard RI Medicaid Provider business process.</p>	
Trigger Event	State-transition Trigger Events: Receipt of program certification application from the provider via the Receive Inbound Transaction process or from the Manage Provider Communication process.	Links to other processes: Enroll Provider
Result	<ol style="list-style-type: none"> 1. Provider is either certified, recertified, or denied certification 2. The Provider is notified about certification results 3. Program areas retain certification data, the MMIS is not updated with certification results at this time. 	Links to other processes: Manage Provider Information Manage Provider Communication
Business Process Steps	<ol style="list-style-type: none"> 1. Start: Receive certification application and other pertinent certification communication data set, or prompt for re-verification of certification criteria of currently enrolled provider 2. Validate application syntax/semantic conformance. [If validation fails, process terminates – see Failures.] 3. Validate program specific certification criteria. 3. End: Medicaid Provider is certified based on program specific criteria. Notify provider of application results. 	Each state will specify its data requirements and rules for each step

PM State-Specific Provider Enrollment Certification

Tier 3: Provider Enrollment Certification		
Item	Details	Links
Shared Data	<ol style="list-style-type: none"> 1. Provider Certification is maintained by each program area [Data is not stored or maintain in the MMIS]. 	
Predecessor	<ul style="list-style-type: none"> ■ The Receive Inbound Transaction authenticates submitter, verifies application format, may translate, may scan, logs in request, and produces the certification application message which is sent to the Provider Enrollment Certification process. ■ The Manage Provider Communication process may send inquiries about the certification process or prompts to re-verify provider ■ The Monitor Performance and Business Activity process may send prompts to reevaluate provider certification criteria ■ The Program Integrity Area processes may request certification review activities 	Receive Inbound Transaction, Manage Provider Communication, Monitor Performance and Business Activity
Successor	<ol style="list-style-type: none"> 1. Enroll Standard RI Medicaid Provider 2. Manage Provider Communication process 3. Monitor Performance and Business Activity process 4. Manage Provider Information process 5. Operations Management Area business processes 	Enroll Standard RI Medicaid Provider, Manage Provider Communication, Manage Provider Information
Constraints	The Provider Enrollment Certification process is specific to certain provider types within the RI Medicaid program.	Business logic differences for type
Failures	Process Failure: Certification application processing terminates or suspends due to: <ol style="list-style-type: none"> 1. Duplicate or cancelled applications 2. Failure to validate application edits 3. Requires additional information to process application 	Result messages
Performance Measures	<ol style="list-style-type: none"> 1. Time to complete Certification process = within __ days 2. Accuracy with which edits are applied = ___% 3. Consistency of decisions = ___% 4. Error rate = __% or less 	

MITA BUSINESS CAPABILITY MATRIX

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Business Relationship Management

BR Establish Business Relationship: Business Capabilities

Establish Business Relationship				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
1. Decisions may take several days . Timelapse of process is within agency, state and federal guidelines .	Timeliness exceeds legal requirements .	Process time can be immediate . Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	Process time is immediate . Clinical data is available in real time . Processes that use clinical data result in immediate action , response, and outcomes.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.
Data Access and Accuracy				
2. Mix of manual and automated processes .	Introduction of automated rules .	Standardized queries; automated alerts . Process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	Business process interfaces with other processes via federated architectures , including direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
3. Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI .	Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI . Automation increases accuracy of data.	Data is accessed / transferred / received via universally standard interfaces . Member-centric/"no wrong door".		
4. There is no single standard for data stored for different types of data (eg, types of	Records for different programs continue to be stored separately but can be accessed	Records are stored in either a single Registry (eg, Provider or Member Registry) or federated Registries that can be accessed by all users of the data. Collaboration w/sister agencies	Medicaid Registries are federated with regional data exchange networks. Information, including clinical,	Medicaid Registries are federated with regional data exchange networks across the country and if desired,

BR Establish Business Relationship: Business Capabilities

Establish Business Relationship				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>providers)</p> <p>5. Staff researches, maintains, and responds to information requests manually.</p> <p>6. Customers have difficulty accessing consistent, quality, or complete information (e.g., about about programs or services).</p> <p>7. Program areas require different rules / criteria and access points for similar business functions.</p>	<p>and aggregated as needed.</p> <p>Responses to requests for information are automated.</p> <p>Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.</p> <p>Rules/criteria and access points for similar business functions are the same across program areas</p>	<p>(one-stop shop).</p> <p>Standard interfaces are used for inquiry and response for acquisition of information. One stop shop with inquiry and response.</p> <p>Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.</p> <p>Standardized application processes. Communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, stakeholder will be able to access information regardless of program.</p>	<p>can be shared among authorized entities within the RHIO.</p> <p>Some inquiries/responses are replaced by automated messages.</p> <p>In addition to Level 3 gains, certain messages are triggered by individual entries into electronic health records for prospective and current members. Access to online PHR or Web portal is available to</p>	<p>internationally.</p> <p>Some inquiries/responses are replaced by automated messages, but on a national level.</p> <p>Stakeholder communications posted by an agency can be accessed anywhere in the country.</p>

BR Establish Business Relationship: Business Capabilities

Establish Business Relationship				
Level 1	Level 2	Level 3	Level 4	Level 5
			support business functions.	
Effort to Perform; Efficiency				
8. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)	Any data exchange partner can send a notification regarding a record update to any other program in the USA.
Cost-Effectiveness				
9. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.	Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.
Accuracy of Process Results				
10. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and	More consistency in decision making/rules / validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Use of clinical data improves consistency of results.	Use of clinical data improves consistency of results on a national scale.

BR Establish Business Relationship: Business Capabilities

Establish Business Relationship				
Level 1	Level 2	Level 3	Level 4	Level 5
information quality and completeness.				
Utility or Value to Stakeholders				
11. Focus is on conducting business functions as efficiently as possible.	Automation and coordination processes enable staff to focus more on member and provider management.	Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.

BR Manage Business Relationship: Business Capabilities

Establish Business Relationship				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
12. Decisions may take several days . Timelapse of process is within agency, state and federal guidelines .	Timeliness exceeds legal requirements .	Process time can be immediate . Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	Process time is immediate . Clinical data is available in real time . Processes that use clinical data result in immediate action , response, and outcomes.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.
Data Access and Accuracy				
13. Mix of manual and automated processes .	Introduction of automated rules .	Standardized queries; automated alerts . Process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	Business process interfaces with other processes via federated architectures , including direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
14. Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI .	Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI . Automation increases accuracy of data.	Data is accessed / transferred / received via universally standard interfaces . Member-centric/"no wrong door".		
15. There is no single standard for data stored for different types of data (eg, types of providers)	Records for different programs continue to be stored separately but can be accessed and aggregated as needed .	Records are stored in either a single Registry (eg, Provider or Member Registry) or federated Registries that can be accessed by all users of the data. Collaboration w/sister agencies (one-stop shop).	Medicaid Registries are federated with regional data exchange networks. Information, including clinical , can be shared among authorized entities within the	Medicaid Registries are federated with regional data exchange networks across the country and if desired, internationally .

BR Manage Business Relationship: Business Capabilities

Establish Business Relationship				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>16. Staff researches, maintains, and responds to information requests manually.</p> <p>17. Customers have difficulty accessing consistent, quality, or complete information (e.g., about about programs or services).</p> <p>18. Program areas require different rules / criteria and access points for similar business functions.</p>	<p>Responses to requests for information are automated.</p> <p>Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.</p> <p>Rules/criteria and access points for similar business functions are the same across program areas</p>	<p>Standard interfaces are used for inquiry and response for acquisition of information. One stop shop with inquiry and response.</p> <p>Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.</p> <p>Standardized application processes. Communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, stakeholder will be able to access information regardless of program.</p>	<p>RHIO.</p> <p>Some inquiries/responses are replaced by automated messages.</p> <p>In addition to Level 3 gains, certain messages are triggered by individual entries into electronic health records for prospective and current members. Access to online PHR or Web portal is available to support business functions.</p>	<p>Some inquiries/responses are replaced by automated messages, but on a national level.</p> <p>Stakeholder communications posted by an agency can be accessed anywhere in the country.</p>

BR Manage Business Relationship: Business Capabilities

Establish Business Relationship				
Level 1	Level 2	Level 3	Level 4	Level 5
Effort to Perform; Efficiency				
19. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)	Any data exchange partner can send a notification regarding a record update to any other program in the USA.
Cost-Effectiveness				
20. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.	Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.
Accuracy of Process Results				
21. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and information quality and	More consistency in decision making/rules / validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Use of clinical data improves consistency of results.	Use of clinical data improves consistency of results on a national scale.

BR Manage Business Relationship: Business Capabilities

Establish Business Relationship				
Level 1	Level 2	Level 3	Level 4	Level 5
completeness.				
Utility or Value to Stakeholders				
22. Focus is on conducting business functions as efficiently as possible.	Automation and coordination processes enable staff to focus more on member and provider management.	Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.

Case Management

CM Manage Case: Business Capabilities

Manage Case				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
23. Decisions may take several days . Timelapse of process is within agency, state and federal guidelines .	Timeliness exceeds legal requirements .	Process time can be immediate . Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	Process time is immediate . Clinical data is available in real time . Processes that use clinical data result in immediate action , response, and outcomes.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.
Data Access and Accuracy				
24. Mix of manual and automated processes .	Introduction of automated rules .	Standardized queries; automated alerts . Process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	Business process interfaces with other processes via federated architectures , including direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
25. Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI .	Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI . Automation increases accuracy of data.	Data is accessed / transferred / received via universally standard interfaces . Member-centric/"no wrong door".		
26. There is no single standard	Records for different programs	Records are stored in either a single Registry (eg, Provider or Member Registry) or federated Registries that can be accessed	Medicaid Registries are federated with regional data	Medicaid Registries are federated with regional data

CM Manage Case: Business Capabilities

Manage Case				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>for data stored for different types of data (eg, types of providers)</p> <p>27. Staff researches, maintains, and responds to information requests manually.</p> <p>28. Customers have difficulty accessing consistent, quality, or complete information (e.g., about about programs or services).</p> <p>29. Program areas require different rules / criteria and access points for similar business functions.</p>	<p>continue to be stored separately but can be accessed and aggregated as needed.</p> <p>Responses to requests for information are automated.</p> <p>Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.</p> <p>Rules/criteria and access points for similar business functions are the same across program areas</p>	<p>by all users of the data.</p> <p>Collaboration w/sister agencies (one-stop shop).</p> <p>Standard interfaces are used for inquiry and response for acquisition of information. One stop shop with inquiry and response.</p> <p>Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.</p> <p>Standardized application processes. Communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, stakeholder will be able to access information regardless of program.</p>	<p>exchange networks. Information, including clinical, can be shared among authorized entities within the RHIO.</p> <p>Some inquiries/responses are replaced by automated messages.</p> <p>In addition to Level 3 gains, certain messages are triggered by individual entries into electronic health records for prospective and current</p>	<p>exchange networks across the country and if desired, internationally.</p> <p>Some inquiries/responses are replaced by automated messages, but on a national level.</p> <p>Stakeholder communications posted by an agency can be accessed anywhere in the country.</p>

CM Manage Case: Business Capabilities

Manage Case				
Level 1	Level 2	Level 3	Level 4	Level 5
			members. Access to online PHR or Web portal is available to support business functions.	
Effort to Perform; Efficiency				
30. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)	Any data exchange partner can send a notification regarding a record update to any other program in the USA.
Cost-Effectiveness				
31. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.	Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.
Accuracy of Process Results				
32. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with	More consistency in decision making/rules / validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Use of clinical data improves consistency of results.	Use of clinical data improves consistency of results on a national scale.

CM Manage Case: Business Capabilities

Manage Case				
Level 1	Level 2	Level 3	Level 4	Level 5
duplication, discrepancies between data stores, and information quality and completeness.				
Utility or Value to Stakeholders				
33. Focus is on conducting business functions as efficiently as possible.	Automation and coordination processes enable staff to focus more on member and provider management.	Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.

CM Manage Medicaid Population Health: Business Capabilities

Manage Medicaid Population Health				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
1. Decisions may take several days . Timelapse of process is within agency, state and federal guidelines .	Timeliness exceeds legal requirements .	Process time can be immediate . Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	Process time is immediate . Clinical data is available in real time . Processes that use clinical data result in immediate action , response, and outcomes.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.
Data Access and Accuracy				
2. Mix of manual and automated processes .	Introduction of automated rules .	Standardized queries; automated alerts . Process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	Business process interfaces with other processes via federated architectures , including direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
3. Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI .	Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI . Automation increases accuracy of data.	Data is accessed / transferred / received via universally standard interfaces . Member-centric/"no wrong door".		
4. There is no single standard for data stored for different types of data (eg, types of providers)	Records for different programs continue to be stored separately but can be accessed and aggregated as needed .	Records are stored in either a single Registry (eg, Provider or Member Registry) or federated Registries that can be accessed by all users of the data. Collaboration w/sister agencies (one-stop shop).	Medicaid Registries are federated with regional data exchange networks. Information, including clinical , can be shared among authorized entities within the	Medicaid Registries are federated with regional data exchange networks across the country and if desired, internationally .

CM Manage Medicaid Population Health: Business Capabilities

Manage Medicaid Population Health				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>5. Staff researches, maintains, and responds to information requests manually.</p> <p>6. Customers have difficulty accessing consistent, quality, or complete information (e.g., about about programs or services).</p> <p>7. Program areas require different rules / criteria and access points for similar business functions.</p>	<p>Responses to requests for information are automated.</p> <p>Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.</p> <p>Rules/criteria and access points for similar business functions are the same across program areas</p>	<p>Standard interfaces are used for inquiry and response for acquisition of information. One stop shop with inquiry and response.</p> <p>Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.</p> <p>Standardized application processes. Communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, stakeholder will be able to access information regardless of program.</p>	<p>RHIO.</p> <p>Some inquiries/responses are replaced by automated messages.</p> <p>In addition to Level 3 gains, certain messages are triggered by individual entries into electronic health records for prospective and current members. Access to online PHR or Web portal is available to support business functions.</p>	<p>Some inquiries/responses are replaced by automated messages, but on a national level.</p> <p>Stakeholder communications posted by an agency can be accessed anywhere in the country.</p>

CM Manage Medicaid Population Health: Business Capabilities

Manage Medicaid Population Health				
Level 1	Level 2	Level 3	Level 4	Level 5
Effort to Perform; Efficiency				
8. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)	Any data exchange partner can send a notification regarding a record update to any other program in the USA.
Cost-Effectiveness				
9. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.	Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.
Accuracy of Process Results				
10. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and information quality and	More consistency in decision making/rules / validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Use of clinical data improves consistency of results.	Use of clinical data improves consistency of results on a national scale.

CM Manage Medicaid Population Health: Business Capabilities

Manage Medicaid Population Health				
Level 1	Level 2	Level 3	Level 4	Level 5
completeness.				
Utility or Value to Stakeholders				
11. Focus is on conducting business functions as efficiently as possible.	Automation and coordination processes enable staff to focus more on member and provider management.	Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.

CM Manage Registry: Business Capabilities

Manage Registry				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
1. Decisions may take several days . Timelapse of process is within agency, state and federal guidelines .	Timeliness exceeds legal requirements .	Process time can be immediate . Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	Process time is immediate . Clinical data is available in real time . Processes that use clinical data result in immediate action , response, and outcomes.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.
Data Access and Accuracy				
2. Mix of manual and automated processes .	Introduction of automated rules .	Standardized queries; automated alerts . Process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	Business process interfaces with other processes via federated architectures , including direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
3. Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI .	Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI . Automation increases accuracy of data.	Data is accessed / transferred / received via universally standard interfaces . Member-centric/"no wrong door".		
4. There is no single standard for data stored for different types of data (eg, types of providers)	Records for different programs continue to be stored separately but can be accessed and aggregated as needed .	Records are stored in either a single Registry (eg, Provider or Member Registry) or federated Registries that can be accessed by all users	Medicaid Registries are federated with regional data exchange networks. Information, including clinical , can be shared among authorized entities	Medicaid Registries are federated with regional data exchange networks across the country and if desired, internationally .

CM Manage Registry: Business Capabilities

Manage Registry				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>5. Staff researches, maintains, and responds to information requests manually.</p> <p>6. Customers have difficulty accessing consistent, quality, or complete information (e.g., about about programs or services).</p> <p>7. Program areas require different rules / criteria and access points for similar business functions.</p>	<p>Responses to requests for information are automated.</p> <p>Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.</p> <p>Rules/criteria and access points for similar business functions are the same across program areas</p>	<p>of the data. Collaboration w/sister agencies (one-stop shop).</p> <p>Standard interfaces are used for inquiry and response for acquisition of information. One stop shop with inquiry and response.</p> <p>Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.</p> <p>Standardized application processes. Communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, stakeholder will be able to access information regardless of program.</p>	<p>within the RHIO.</p> <p>Some inquiries/responses are replaced by automated messages.</p> <p>In addition to Level 3 gains, certain messages are triggered by individual entries into electronic health records for prospective and current members. Access to online PHR or Web portal is available to support business functions.</p>	<p>Some inquiries/responses are replaced by automated messages, but on a national level.</p> <p>Stakeholder communications posted by an agency can be accessed anywhere in the country.</p>

CM Manage Registry: Business Capabilities

Manage Registry				
Level 1	Level 2	Level 3	Level 4	Level 5
Effort to Perform; Efficiency				
8. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)	Any data exchange partner can send a notification regarding a record update to any other program in the USA.
Cost-Effectiveness				
9. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.	Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.
Accuracy of Process Results				
10. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between	More consistency in decision making/rules / validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Use of clinical data improves consistency of results.	Use of clinical data improves consistency of results on a national scale.

CM Manage Registry: Business Capabilities

Manage Registry				
Level 1	Level 2	Level 3	Level 4	Level 5
data stores, and information quality and completeness.				
Utility or Value to Stakeholders				
11. Focus is on conducting business functions as efficiently as possible.	Automation and coordination processes enable staff to focus more on member and provider management.	Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.

Contractor Management

CO1 Award Health Services Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Decisions may take several days.</i>	<i>Process takes less time than Level 1.</i>	<i>Turnaround time can be immediate.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.</i>
<i>Data Access and Accuracy</i>				
2. <i>Staff contact external and internal document verification sources via phone, fax.</i>	<i>Verification is completed via Web portals, email, dial-up, POS, and EDI. Automation increases</i>	<i>Verification is completed via MITA standard interfaces.</i>	<i>Direct and/or virtual access to clinical data in addition to administrative data in real time.</i>	<i>Interoperability nationwide.</i>
3. <i>Indeterminate format for proposal data.</i>	<i>Application data are standardized within the state.</i>	<i>Application data are standardized nationally.</i>		
4. <i>Contractor submit applications via paper.</i>	<i>Contractors can submit applications via a portal.</i>	<i>Contractors can submit applications via MITA standard interfaces.</i>		
5.			<i>Clinical data, if useful in processing the enrollment request is accessible by direct access.</i>	
<i>Effort to Perform; Efficiency</i>				
6. <i>Much of the information is manually validated.</i>	<i>Verifications are a mix of manual and automated steps.</i>	<i>All verifications can be automated. Some manual steps may continue.</i>	<i>Manual steps only required for exception handling.</i>	
7.		<i>Recertification notices are</i>		

CO1 Award Health Services Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
		<i>automatically generated.</i>		
8.			<i>External and internal validation sources automatically send notice of change in contractor status.</i>	<i>Any data exchange partner can send a notification regarding a contractor enrolled with the state Medicaid program.</i>
9.				<i>Level 3 and 4 capabilities augmented by national interoperability, permitting the enrollment process to send inquiries to any other agency, state, federal, or other entities regarding the status of a contractor.</i>
<i>Cost-Effectiveness</i>				
<i>10. Requires large numbers of staff.</i>	<i>Requires fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	<i>Staff focused on performance outcomes; care/disease management; stakeholder satisfaction on a national level.</i>
<i>Accuracy of Process Results</i>				
<i>11. Decisions may be inconsistent.</i>	<i>Consistency is improved.</i>	<i>Rules are consistently applied. Decisions are uniform.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	
12.		<i>Services will created for the following steps and can be shared.</i> <ol style="list-style-type: none"> 1. <i>Verify Credentials</i> 2. <i>Verify ID</i> 3. <i>Assign ID</i> 		

CO1 Award Health Services Contract: Business Capabilities

CO1 Award Health Services Contract: Business Capabilities				
Level 1	Level 2	Level 3	Level 4	Level 5
		4. Assign Rates 5. Negotiate Contract		
<i>Utility or Value to Stakeholders</i>				
13. Business process complies with agency and state requirements	The agency benefit from introduction of automation	Agencies benefit from sharing of the business service and information with other agencies.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.	

CO1 Close out Health Services Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process (TBD)</i>				
<i>1. Inconsistent timing for response to primary client.</i>	<i>Enhanced consistent timing for response to primary client.</i>	<i>Turnaround time can be immediate.</i>	<i>Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Most services instantly authorized or denied from point of service; payment automatically established without need of invoice.</i>
<i>1. Data Access and Accuracy</i>				
<i>2. Indeterminate connectivity to client</i>	<i>Point-to-point or wrapped connectivity to client. Point-to-point interfaces (trading partner agreements) segregated by interface type</i>	<i>Virtual access to administrative and clinical records. Increased use of clinical data</i>	<i>Virtual records. Use of clinical data.</i>	<i>Point-to-point collaboration. Full interoperability with other local, state, and federal programs to provide complete virtual patient clinical record and administrative data.</i>
<i>3. External inputs & outputs are received/sent manually via paper, telephone, & fax</i>	<i>Transactions are received and responded to via EDI, Web Portal</i>	<i>Data is accessed/transferred/received via MITA standard interfaces.</i>		
<i>4. Multiple data formats and semantics</i>	<i>Different interfaces with different data format and semantics</i>	<i>Focused data – data of record. Use of metadata</i>	<i>Focused data – data of record Use of metadata</i>	<i>Metadata – Shared nationally</i>
<i>Effort to Perform; Efficiency</i>				
<i>5. Transactions are individually reviewed using inconsistent interpretation of guidelines responded to via paper/USPD or fax</i>	<i>Use of electronic Claim Attachment for Adjudication.</i>	<i>Self adjusting business rules</i>	<i>Self adjusting business rules</i>	<i>Content sensitive business logic. Business Process Management</i>

CO1 Close out Health Services Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
6.		<i>Clinical staff focuses on exception cases</i>	<i>Clinical staff focuses on exception cases</i>	
<i>Cost-Effectiveness</i>				
<i>7. Large number of staff required to perform business process.</i>	<i>Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	<i>Staff focused on performance outcomes; care/disease management; stakeholder satisfaction on a national level.</i>
<i>Accuracy of Process Results</i>				
8.		<i>Use of clinical data to increase the accuracy of processes</i>	<i>Use of clinical data to increase the accuracy of processes</i>	<i>Access to national clinical guidelines</i>
<i>Utility or Value to Stakeholders</i>				
9.		<i>Members empowered to make own treatment decisions</i>	<i>Members empowered to make own treatment decisions</i>	

CO1 Manage Health Services Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process (TBD)</i>				
1. <i>Timeliness of responses to inquiries and data reporting is indeterminate.</i>	<i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.</i>
<i>Data Access and Accuracy</i>				
2. <i>At this level, the Manage Health Services Contract business process is likely primarily paper/phone/fax based processing and some proprietary EDI.</i>	<i>At this level, the Manage Health Services Contract business process is increasing its use of electronic interchange.</i>	<i>At this level the Manage Health Services Contract business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.</i>	<i>At this level, the Manage Health Services Contract business process interfaces with other processes via federated architectures.</i>	<i>At this level, the Manage Health Services Contract business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.</i>
3.		<i>Data is standardized for automated electronic interchanges.</i>		
4. <i>Programs are siloed so uncoordinated.</i>	<i>Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data.</i>	<i>Records are stored in either a single Registry or federated Registries that can be accessed by all users of the data.</i>		

CO1 Manage Health Services Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Effort to Perform; Efficiency</i>				
5. <i>Staff contact external and internal document verification sources via phone, fax.</i>	<i>Verifications are a mix of manual and automated steps.</i>	<i>All verifications can be automated.</i>		
<i>Cost-Effectiveness</i>				
6. <i>Large number of staff required to perform business process.</i>	<i>Less staff required to perform business process. Automation leads to fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	<i>Staff focused on performance outcomes; care/disease management; stakeholder satisfaction on a national level</i>
<i>Accuracy of Process Results</i>				
7. <i>Inconsistent communication.</i>	<i>Centralization increases consistency of communications.</i>	<i>Communications are consistent, timely and appropriate.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	
<i>Utility or Value to Stakeholders</i>				
8. <i>Business process complies with agency and state requirements</i>	<i>The agency benefit from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

CO2 Award Administrative Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process (TBD)</i>				
1. Decisions may take several days.	Process takes less time than Level 1.	Turnaround time can be immediate.	Process time is immediate. Clinical data is available in real time.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.
<i>Data Access and Accuracy</i>				
2. At this level, the Manage Administrative Contracts business process uses indeterminate format for application data.	At this level, the Manage Administrative Contract business process uses application data that is standardized within the state.	At this level, the Manage Administrative Contract uses application data that is standardized nationally.	At this level, the Manage Administrative Contract business process interfaces with other processes via federated architectures.	At this level, the Manage Administrative Contract business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
3. Contractors submit applications via paper.	Contractors can submit applications via a portal.	Contractors can submit applications via a MITA standard interfaces		
<i>Effort to Perform; Efficiency</i>				
4. Much of the information is manually validated.	Information is mostly validated automatically.	Some manual steps may continue.		
5. Staff contact external and internal document verification sources via phone, fax.	Verifications are a mix of manual and automated steps.	All verifications can be automated.		
6.		Services for the following steps and can be shared. 1. Verify Credentials	Data triggers registry updates and pushes data to other applications (eg, EHRs,	

CO2 Award Administrative Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
		2. <i>Verify ID</i> 3. <i>Assign ID</i> 4. <i>Assign Rates</i> 5. <i>Negotiate Contract</i>	<i>Immunization registries; and care/disease management applications)</i>	
<i>Cost-Effectiveness</i>				
<i>7. Requires large numbers of staff.</i>	<i>Requires fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	<i>Staff focused on performance outcomes; care/disease management; stakeholder satisfaction on a national level.</i>
<i>Accuracy of Process Results</i>				
<i>8. Decisions may be inconsistent.</i>	<i>Consistency is improved.</i>	<i>Rules are consistently applied. Decisions are uniform.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	
<i>Utility or Value to Stakeholders</i>				
<i>9. Business process complies with agency and state requirements</i>	<i>The members and the agency benefit from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

CO2 Close out Administrative Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. Inconsistent timing for response to primary client.	Process takes less time than Level 1.	Turnaround time can be immediate.	Process time is immediate. Clinical data is available in real time.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.
<i>Data Access and Accuracy</i>				
2. At this level the Close-Out Administrative Contract business process uses indeterminate connectivity to client.	At this level, the Close-Out Administrative Contract business process is beginning to use electronic interchange and standardized application data within the state.	At this level, the Close-Out Administrative Contract business process has almost eliminated its use of non-electronic interchange and uses application data that is standardized nationally.	At this level, the Close-Out Administrative Contract business process interfaces with other processes via federated architectures.	At this level, the Close-Out Administrative Contract business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
3. Internal and external inputs and outputs are received or sent manually via paper, telephone and fax.	Contractors can submit applications via a portal.	Some manual steps may continue.		
<i>Effort to Perform; Efficiency</i>				
4. Verification is manual and if difficult then may require a longer amount of time.	Verifications are a mix of manual and automated steps.	All verifications can be automated.	Data triggers registry updates and pushes data to other applications	
<i>Cost-Effectiveness</i>				
5. Requires large numbers of staff.	Requires fewer staff.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff	Staff focused on performance outcomes; care/disease management; stakeholder

CO2 Close out Administrative Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
			<i>requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	<i>satisfaction on a national level.</i>
<i>Accuracy of Process Results</i>				
6. <i>Decisions may be inconsistent.</i>	<i>Consistency is improved.</i>	<i>Rules are consistently applied. Decisions are uniform.</i>	<i>Self adjusting business rules.</i>	
<i>Utility or Value to Stakeholders</i>				
7. <i>Business process complies with agency and state requirements</i>	<i>The members and the agency benefit from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Readily/instantaneous available data to address linguistic, cultural or competency-based needs.</i>	

CO2 Manage Administrative Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. Decisions may take several days.	Process takes less time than Level 1.	Turnaround time can be immediate.	Process time is immediate. Clinical data is available in real time.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.
<i>Data Access and Accuracy</i>				
2. At this level, the Monitor Administrative Services Contract business process uses indeterminate format for application data.	At this level, the Monitor Administrative Services Contract business process uses application data that is standardized within the state.	At this level, the Monitor Administrative Services Contract uses application data that is standardized nationally.	At this level, the Monitor Administrative Services Contract business process interfaces with other processes via federated architectures.	At this level, the Monitor Administrative Services Contract business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
3. Contractors submit applications via paper.	Contractors can submit applications via a portal.			
4.		Services created for the following steps and can be shared. <ol style="list-style-type: none"> 1. Verify Credentials 2. Verify ID 3. Assign ID 4. Assign Rates 5. Negotiate Contract 		
<i>Effort to Perform; Efficiency</i>				
5. Much of the information is manually validated.		Some manual steps may continue.		

CO2 Manage Administrative Contract: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
6. Staff contact external and internal document verification sources via phone, fax.	Verifications are a mix of manual and automated steps.	All verifications can be automated.		
<i>Cost-Effectiveness</i>				
7. Requires large numbers of staff.	Requires fewer staff.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.	Staff focused on performance outcomes; care/disease management; stakeholder satisfaction on a national level.
<i>Accuracy of Process Results</i>				
8. Decisions may be inconsistent.	Consistency is improved.	Rules are consistently applied. Decisions are uniform.		
<i>Utility or Value to Stakeholders</i>				
9. Business process complies with agency and state requirements	The members and the agency benefit from introduction of automation	Agencies benefit from sharing of the business service and information with other agencies.		

CO3 Inquire Contractor Information: Business Capabilities

Inquire Contractor Information				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
12. Decisions may take several days . Timelapse of process is within agency, state and federal guidelines .	Timeliness exceeds legal requirements .	Process time can be immediate . Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	Process time is immediate . Clinical data is available in real time . Processes that use clinical data result in immediate action , response, and outcomes.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.
Data Access and Accuracy				
13. Mix of manual and automated processes .	Introduction of automated rules .	Standardized queries; automated alerts . Process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	Business process interfaces with other processes via federated architectures , including direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
14. Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI .	Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI . Automation increases accuracy of data.	Data is accessed / transferred / received via universally standard interfaces . Member-centric/"no wrong door".		
15. There is no single standard for data stored for different types of data (eg, types of providers)	Records for different programs continue to be stored separately but can be accessed and aggregated as needed .	Records are stored in either a single Registry (eg, Provider or Member Registry) or federated Registries that can be accessed by all users of the data. Collaboration w/sister agencies (one-stop shop).	Medicaid Registries are federated with regional data exchange networks. Information, including clinical , can be shared among authorized entities within the	Medicaid Registries are federated with regional data exchange networks across the country and if desired, internationally .

CO3 Inquire Contractor Information: Business Capabilities

Inquire Contractor Information				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>16. Staff researches, maintains, and responds to information requests manually.</p> <p>17. Customers have difficulty accessing consistent, quality, or complete information (e.g., about programs or services).</p> <p>18. Program areas require different rules / criteria and access points for similar business functions.</p>	<p>Responses to requests for information are automated.</p> <p>Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.</p> <p>Rules/criteria and access points for similar business functions are the same across program areas</p>	<p>Standard interfaces are used for inquiry and response for acquisition of information. One stop shop with inquiry and response.</p> <p>Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.</p> <p>Standardized application processes. Communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, stakeholder will be able to access information regardless of program.</p>	<p>RHIO.</p> <p>Some inquiries/responses are replaced by automated messages.</p> <p>In addition to Level 3 gains, certain messages are triggered by individual entries into electronic health records for prospective and current members. Access to online PHR or Web portal is available to support business functions.</p>	<p>Some inquiries/responses are replaced by automated messages, but on a national level.</p> <p>Stakeholder communications posted by an agency can be accessed anywhere in the country.</p>

CO3 Inquire Contractor Information: Business Capabilities

Inquire Contractor Information				
Level 1	Level 2	Level 3	Level 4	Level 5
Effort to Perform; Efficiency				
19. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)	Any data exchange partner can send a notification regarding a record update to any other program in the USA.
Cost-Effectiveness				
20. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.	Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.
Accuracy of Process Results				
21. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and information quality and	More consistency in decision making/rules / validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Use of clinical data improves consistency of results.	Use of clinical data improves consistency of results on a national scale.

CO3 Inquire Contractor Information: Business Capabilities

Inquire Contractor Information				
Level 1	Level 2	Level 3	Level 4	Level 5
completeness.				
Utility or Value to Stakeholders				
22. Focus is on conducting business functions as efficiently as possible.	Automation and coordination processes enable staff to focus more on member and provider management.	Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.

CO3 Manage Contractor Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
2. There are delays in completing updates.	Updates are timelier.	Turnaround time can be immediate.	Process time is immediate. Clinical data is available in real time.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.
<i>Data Access and Accuracy</i>				
3. Requests are received from disparate sources in indeterminate formats.	Requests are standardized and automated. More automation of rules to maintain integrity of data repository.	Determinate interfaces (trigger event and results; messages to external entities), standardized data, consistent business rules and decisions, easy to change business logic. Manage Contractor Information is handled by a business service.	Business process interfaces with other processes via federated architectures.	
4. Irregular notification of change to users and processes that need to know.	Change is immediately available to users and processes that need to know.			
<i>Effort to Perform; Efficiency</i>				
5. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners.	Data triggers registry updates and pushes data to other applications (eg, EHRs, Immunization registries; and care/disease management applications)	

CO3 Manage Contractor Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Cost-Effectiveness</i>				
6. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.	Staff focused on performance outcomes; care/disease management; stakeholder satisfaction on a national level.
<i>Accuracy of Process Results</i>				
7. Validation is inconsistent and not rules-based.	Validation is consistent. More consistency in validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Incorporation of clinical data improves accuracy of some responses.	
8. Duplicate entries may go undetected.				
<i>Utility or Value to Stakeholders</i>				
9. Business process complies with agency and state requirements	The members and the agency benefit from introduction of automation	Agencies benefit from sharing of the business service and information with other agencies.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.	

CO4 Perform Potential Contractor Outreach: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Decisions may take several days.</i>	<i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than level 1.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i> <i>Turnaround time can be immediate.</i>	<i>Process time is immediate. Clinical data is available in real time.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.</i>
<i>Data Access and Accuracy</i>				
2. <i>At this level, the Perform Potential Contractor Outreach process is primarily conducted via paper and phone.</i>	<i>At this level, the Perform Potential Contractor Outreach process primarily conducted via paper and phone. However, states use Websites, TV, radio and advertisements to distribute information to targeted contractors.</i>	<i>At this level, the Perform Potential Contractor Outreach process is primarily electronic, with paper used only secondarily.</i>		
3. <i>Contact data is not standardized.</i>	<i>Some standardization of data and format in process.</i>	<i>Contractor registries use standardized contact data, including NPS address standards, to alleviate postal delivery failures.</i>		

CO4 Perform Potential Contractor Outreach: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p>4. Outreach is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target populations; of inconsistent quality; may encounter obstacles to delivery, e.g., incorrect or lack of contact information.</p>	<p>Outreach may be more coordinated because programs are able to share analysis/ performance measures based on increase standardization of administrative data, somewhat standardized clinical data available via registries, and improved data manipulation for decision support.</p>	<p>Access to standardized electronic clinical data via registries, electronic prescribing, claims and service review attachments and electronic health records, as well as use of GIS and socio-economic indicators, which provide basis for policy directives, support targeting contractors for outreach.</p> <p>Outreach is centralized which ensures that regardless of outreach campaign, current and prospective providers will be able to access information. This ensures agency-wide outreach coordination and greater ability to measure the efficacy of outreach.</p>	<p>At this level, the Perform Potential Contractor Outreach process may include automated targeting of providers via RHIO, PHRs and EHRs based on analysis of performance and business activity monitoring of state administrative, clinical and demographic data, and their resulting policy directives.</p>	<p>At this level, Perform Potential Contractor Outreach process may include collaborative discernment of individual contractor entities or organizations to whom outreach communications should be sent based on indicator algorithms that trigger during business activity monitoring at the agency, in the RHIO, EHRs, and the individuals' PHR.</p>
<i>Effort to Perform; Efficiency</i>				
<p>5. Staff develops and maintains materials manually.</p>	<p>Materials can be posted on a Web site for downloading by contractor.</p>	<p>Outreach and education materials are available via state Medicaid portal and are shared with other collaborating agencies.</p>		
<i>Cost-Effectiveness</i>				
<p>6. Paper communication is costly.</p>	<p>Program quality improvement initiatives are</p>	<p>Use of electronic communications makes</p>	<p>Full automation of the process plus access to clinical</p>	

CO4 Perform Potential Contractor Outreach: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
	<i>promoting more sophisticated performance measures that provide clinical and administrative indicators of populations needed to target outreach to contractors to ensure population health and access, but at great expense.</i>	<i>outreach material more feasible and cost-effective.</i>	<i>data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	
<i>Accuracy of Process Results</i>				
<i>7. lacks data to appropriately target populations; of inconsistent quality; may encounter obstacles to delivery, e.g., incorrect or lack of contact information.</i>	<i>More standardization and consistency in targeting populations.</i>	<i>Access to standardized electronic clinical data via registries, electronic prescribing, claims and service review attachments and electronic health records, as well as use of GIS and socio-economic indicators, support targeting contractors for outreach.</i>	<i>automated targeting of providers via RHIO, PHRs and EHRs</i>	<i>collaborative discernment of individual contractor entities or organizations to whom outreach communications should be sent based on indicator algorithms that trigger during business activity</i>
<i>Utility or Value to Stakeholders</i>				
<i>8. No emphasis on linguistic, cultural or competency-based considerations.</i>	<i>Centralization assists with more emphasis on linguistic, cultural or competency-based considerations.</i>	<i>Feasible and cost-effective to emphasize on linguistic, cultural or competency-based considerations. Improves selection of providers for members. Improves stakeholder satisfaction.</i>	<i>Readily/instantaneous available data to address linguistic, cultural or competency-based needs.</i>	<i>Readily/instantaneous available data to address linguistic, cultural or competency-based needs on a national level.</i>

CO4 Support Contractor Grievance and Appeal: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Decisions may take several days.</i>	<i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than level 1.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i> <i>Turnaround time can be immediate.</i>	<i>Process time is immediate. Clinical data is available in real time.</i>	<i>This optimizes resources, timeliness, and disposition consistency.</i>
<i>Data Access and Accuracy</i>				
2. <i>At this level, the Support Contractor Grievance & Appeal process is entirely paper based, which results in poor document management and process inefficiencies that impact timeliness.</i>	<i>At this level, the Support Contractor Grievance & Appeal process conducts much of its business electronically, except where paper documents are required by law, which are OCR'd for electronic data capture.</i>	<i>At this level, the Support Contractor Grievance & Appeal process continues to conduct most of its business electronically, except where paper documents are required by law, which are OCR'd for electronic data capture. However, clinical data is still paper-based and difficult to access in a timely manner.</i>	<i>At this level, the Support Contractor Grievance & Appeal process is able to interface with RHIOs to access standardized clinical data needed for review and disposition of grievances and appeals with utmost timeliness.</i>	<i>At this level, the Support Contractor Grievance & Appeal process enables contractors to file grievances and appeals in a collaborative environment via PHRs and EHRs in which the relevant administrative and clinical details is reviewed automatically and a preliminary disposition is made that can be raised for further evaluation by a reviewer.</i>
3. <i>Grievances and appeals are filed, managed, and resolved by siloed programs, leading to inconsistent application or</i>	<i>Agencies begin to centralize or standardize the administration of this process to achieve economies of scale, thereby increasing</i>	<i>Access to administrative data needed to review and dispose of the grievances and appeals is readily available and standardized, improving</i>		

CO4 Perform Potential Contractor Outreach: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>relevant laws and administrative policies and inhibiting performance monitoring.</i>	<i>coordination and improving consistency by which rules are applied and appeals disposed.</i>	<i>consistency and timeliness of dispositions.</i>		
<i>Effort to Perform; Efficiency</i>				
4.	<i>Initial review and information gathering must be conducted by phone or in person.</i>	<i>Access to administrative data needed to review and dispose of the grievances and appeals is readily available and standardized, improving consistency and timeliness of dispositions.</i>	<i>Initial review and information gathering can be conducted electronically via PHRs.</i>	
5.		<i>The process supports the Program Quality Management Business Area by providing data about the types of: grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities that may reduce the issues that give rise to grievances and appeals.</i>	<i>Program Quality Management is better able to apply performance measures and focus business activity monitoring on operational data to detect opportunities for process, provider and contractor improvements to alleviate issues that give rise to grievances and appeals.</i>	
<i>Cost-Effectiveness</i>				
6. <i>Process is labor-intensive. Results take several months.</i>	<i>Automation of some research steps reduces level of staffing required to manage a case.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduce staff</i>	<i>This optimizes resources, timeliness, and disposition consistency.</i>

CO4 Perform Potential Contractor Outreach: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
			<i>requirements to a core team of professionals who monitor stakeholder satisfaction with responsiveness to inquiries.</i>	
<i>Accuracy of Process Results</i>				
<i>7. Terms of the settlement or results of the hearing are manually documented according to the administrative rules of the state.</i>	<i>Automation is introduced into the case management process. Results are documented and recorded automatically and can be accessed and reviewed as needed.</i>	<i>MITA standard interface improves accuracy of case results.</i>	<i>Analysis of business rules to which the agency must adhere is automated, improving review turn around and consistency.</i>	<i>Gains of Level 4 are further improved by access to information on a national basis.</i>
<i>8. Communications are not consistent.</i>	<i>Communications are more consistent.</i>	<i>Communications are consistent and timely.</i>		<i>This optimizes resources, timeliness, and disposition consistency.</i>
<i>Utility or Value to Stakeholders</i>				
<i>9. Providers may have difficulty:</i> <ul style="list-style-type: none"> • <i>Finding the “Right Door” for filing grievances and appeals</i> • <i>Accessing program rules to discern the merit of their grievance or appeal</i> • <i>Getting assistance on their case or providing additional information</i> • <i>Receiving consistent responses or communications that are</i> 	<i>Contractors have limited access to program rules to discern whether their grievances or appeals have merit.</i>	<i>Contractors can electronically access program rules to discern whether their grievances or appeals have merit. Initial review and information gathering can be conducted electronically via phone and email.</i>	<i>Providers can access program rules to discern whether their grievances or appeals have merit.</i>	

CO4 Perform Potential Contractor Outreach: Business Capabilities

<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Level 5</i>
<i>linguistically, culturally and competency appropriate</i>				

Member Management

ME Determine Eligibility: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Decisions take several days.</i>	<i>Process takes less time than Level 1.</i>	<i>Turnaround time can be immediate.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.</i>
<i>Data Access and Accuracy</i>				
2. <i>At this level, the Determine Eligibility business process is designed to serve social services programs and FFS Medicaid programs.</i>	<i>At this level, the Determine Eligibility business process is by extended by "work-arounds" to meet the needs of programs besides FFS.</i>	<i>At this level, the Determine Eligibility business process benefits from member-centric, No Wrong Door initiatives and the technology support provided by SOA and rules-engines.</i>	<i>At this level, the Determine Eligibility business process ease of access to external sources of data, including clinical data, augment Level 3 capabilities.</i>	<i>At this level, the Determine Eligibility business process capabilities are augmented by national interoperability, permitting the eligibility process to send inquiries to any other agency, state, federal, or other entities in any part of the country.</i>
3. <i>The process is constrained by FAMIS or state eligibility system functionality.</i>				
4. <i>Indeterminate format for application data.</i>	<i>Application data may be standardized within the state. Some efforts are made toward standardizing eligibility determination data so that it is more easily shared and</i>	<i>Application data are standardized.</i>		

ME Determine Eligibility: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
	<i>compared.</i>			
5. <i>Applications are paper only.</i>	<i>Some applications still on paper.</i>	<i>Applicants may initiate an application from home or a community location. A consolidated “Determine eligibility process” manages all categories.</i>		
6. <i>At Level 1, eligibility determination may occur in silos without sharing or coordination, i.e., different processes for each type of eligibility.</i>	<i>At Level 2, eligibility determination may still occur in silos without sharing or coordination.</i>		<i>Direct access to clinical data improves the determination process through immediate validation in the medical record. Manual steps only required for exception handling.</i>	
7. <i>Benefit packages selections have pre-set services and provider types. Each eligible may be offered only packages available via eligibility determination pathway taken. Within each silo, eligible may only be assigned to the best available package available despite eligibility for more expansive services because systems may be limited to supporting one eligibility span at a time.</i>	<i>Benefit package selections may still be limited for traditional Medicaid programs. However, Waiver programs may be structured to permit more flexibility around selection of services and providers within a benefit package.</i>	<i>All programs introduce flexibility within benefit packages, enabling “consumer driven” health care with more choices among services and provider types available within the funding limits of all benefit packages for which the member is eligible. Design of benefit packages is manual and is based on limited paper-based access to external clinical data.</i>	<i>Design of benefit packages is automated with electronic access to electronic clinical data.</i>	<i>Consumer-driven benefit packages are designed and updated real time based on collaborative interfaces with members’ federated electronic health records. As clinical data indicates altering priority of services, the benefit package is optimally reconfigured for best health outcome within funding limits.</i>

ME Determine Eligibility: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Effort to Perform; Efficiency</i>				
8. <i>There are many pathways for determining eligibility.</i>	<i>There are many pathways for determining eligibility for low income applicants.</i>	<i>At Level 3, different types of eligibility pathways are merged into a single process. This is a "one-stop-shop" perspective for the applicant. One door to all applicable eligibility applications.</i>		
9. <i>In addition, transfers must be scheduled for batch transmission outside of production cycles, which impedes timely availability.</i>				
10. <i>Spend-down amounts are calculated manually. Member's record reflects whether spend-down amount is reached. Until spend-down is met, the Edit process in the Provider Payment Adjudication business area will flag the member's claims to be denied based on eligibility.</i>	<i>Spend-down continues to be calculated manually.</i>	<i>Spend-down is calculated automatically by the Calculate Spend-down process in the Operations Management, Member Payment business area. Spend-down is treated as a deductible that these eligibles must pay out-of-pocket before Medicaid will pay. The spend-down amount in the member's record is decremented by this process. Until spend-down is met, the Edit process in Provider</i>		

ME Determine Eligibility: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
		<i>Payment Adjudication will deny the claim. Once spend-down is met, the Edit process will validate that the claim passes eligibility edits.</i>		
11.			<i>Re-determination notices are automatically generated.</i>	
<i>Cost-Effectiveness</i>				
<i>12. Requires large staff.</i>	<i>Requires fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.</i>	
<i>Accuracy of Process Results</i>				
<i>13. Decisions may be inconsistent.</i>	<i>Consistency is improved.</i>	<i>Rules are consistently applied. Decisions are uniform. Some manual steps may continue.</i>		<i>Agency receives automated notifications from the SSA and other in-state and other state and federal agencies with which it has data sharing agreements.</i>
<i>14. When eligibility information is transferred from FAMIS to MMIS, it</i>				

ME Determine Eligibility: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>must be converted and data is lost.</i>				
<i>15. Staff contact external and internal document verification sources via phone, fax. Information is manually validated.</i>		<i>All verifications can be automated.</i>	<i>External and internal validation sources automatically send notice of change in member status, e.g., change in income, other coverage, residency, immigrant status, spend-down accumulation</i>	
<i>Utility or Value to Stakeholders</i>				
<i>16. Services and providers are selected without emphasis on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally appropriate, and functional</i>	<i>Centralization assists with more emphasis on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally appropriate, and functional</i>	<i>Improved emphasis on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally appropriate, and functional</i>	<i>Services and providers are selected within funding limits of benefit packages available to the member based on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally appropriate, and functional competencies.</i>	

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. Decisions on application may take several days; longer if verification of information is difficult.</p> <p>2. Contractors do not receive timely enrollment information. Staff must send paper enrollment notification to contractors.</p> <p>3.</p> <p>4.</p>	<p><i>Process takes less time than Level 1. Staff collaborates with other agencies to receive, triage, and process paper and some electronic applications per "No Wrong Door" policies so that applicants can apply once for all programs.</i></p> <p><i>Although data is electronic, much of the review and verification of information for waiver programs must be done manually.</i></p> <p><i>Managed care enrollment is rule driven and automated; applicants and members</i></p>	<p><i>Turnaround time on application decision can be immediate. Enrollment pathways are merged into a single process. This is a "No Wrong Door" perspective for the member - one door to all applicable eligibility/enrollment processes.</i></p> <p><i>Medicaid and contractor member registries are updated in near real time as changes occur.</i></p>	<p><i>Turnaround time is immediate.</i></p>	<p><i>Turnaround time is immediate, on a national scale.</i></p>

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
	<i>communicate via Web portal for increased timeliness.</i>			
<i>Data Access and Accuracy</i>				
<p>5. Enrollment data and format are indeterminate.</p> <p>6. Enrollment applications are not standardized and may still be hard copy.</p> <p>7. Some enrollment records are stored electronically but storage is not centralized.</p>	<p><i>Enrollment data are standardized within the agency.</i></p> <p><i>Enrollment applications are standardized and electronic; they are received from many sources and triaged to appropriate programs for processing. HIPAA contractors receive standardized 834 Enrollment Transaction, but non-HIPAA contractors receive state-specific enrollment transactions.</i></p> <p><i>Enrollment records for different programs continue to be stored separately but can be accessed and aggregated as needed.</i></p>	<p><i>Enrollment application and exchange data are standardized nationally among Medicais improving access and accuracy.</i></p> <p><i>All programs use the HIPAA 834 Enrollment transaction and implement a standard response transaction from the contractors for corrections.</i></p> <p><i>Enrollment records are stored in either a single member registry or federated Agency</i></p>	<p><i>Agency automatically receives standardized, timely, and complete enrollment data notifications about members for verification and adjudication purposes.</i></p> <p><i>Medicaid member registries are federated with regional data exchange networks.</i></p>	<p><i>Member registries are federated with regional data exchange networks across the country and if desired,</i></p>

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>8.</p> <p>9. Member data, including ID, demographics and health status, is not comparable across programs reducing ability to monitor program outcomes or detect fraud and abuse.</p> <p>10. Notifications to contractors are state-specific and differ by contractor type.</p>	<p>Although data comparability is improved and supports use of performance measures to evaluate providers, performance data is only periodically measured and requires sampling and statistical calculation.</p>	<p>member registries that can be accessed by all applications. All member enrollment records are stored and accessible with service calls in the Medicaid member registry.</p> <p>Providers, members, and state enrollment staff have secure access to appropriate and accurate data on demand.</p> <p>Member ids are linked algorithmically based on other standardized data so that enrollment records are automatically linked across programs.</p>	<p>Agency may auto/ad hoc query registries for standardized, timely, and complete enrollment data about members for verification and adjudication purposes.</p> <p>Authorized, authenticated parties have virtual, instant access to member data locally.</p>	<p>internationally.</p> <p>Authorized, authenticated parties have virtual, instant access to enrollment data, nationally.</p>

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Effort to Perform; Efficiency</i>				
<p>11. Enrollment may occur in silos without coordination, i.e., different processes and multiple pathways for each type of enrollment.</p> <p>12. Staff makes decisions autonomously and without consultation with other programs.</p> <p>13.</p>	<p>Enrollment processes continue to be handled by siloed programs according to program-specific rules.</p>	<p>Medicaid centralizes all member enrollment processes; has a single set of enrollment rules.</p> <p>Contractors and providers can query the registry to determine eligibility and program enrollment. Contractors may batch download enrolled members rather than receive the HIPAA 834.</p>	<p>Any data exchange partner within a federated region can query and receive appropriate data relating to an enrolled member.</p>	<p>Any data exchange partner nationally, and even internationally can query and receive appropriate data relating to an enrolled member.</p>

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>14. Applicants and members can submit applications, make inquiries, and choose providers and MCOs on paper.</p> <p>15.</p> <p>16. Staff manually verifies financial, socio-economic and health status information. Staff contact external and internal financial, socio-economic, demographic and health status verification sources via phone, fax.</p>	<p>Applicants and members can submit enrollment applications, make inquiries, and choose providers and MCOs electronically via a portal which lessens effort.</p> <p>Applicants may submit applications online, but results are not real time.</p> <p>Verifications and enrollment are a mix of manual and automated steps.</p>	<p>Applications are only submitted electronically Automated verification and application response are real time.</p> <p>Enrollments and verifications are full automated. Verifications are still between trading partners and centralized repositories vs. queries to federated information sources.</p>	<p>The applicant is also able to use online PHR or Web portal to fill out a pre-populated application.</p> <p>Internal and regional person/patient registries and other enrollment data sources can be auto/ad hoc queried for changes in verification or enrollment status; supports detection of fraudulent or erroneous in real time.</p>	<p>Nationally interoperable person/patient registries and other enrollment data sources (SSA) automatically send notice of changes in verification or enrollment status, eliminating the need to re-verify; supports detection of fraudulent or erroneous enrollment in real time anywhere in the U.S. Agency receives automated enrollment notifications from the SSA, EHRs, PHRs, intra- and interstate sources and federal agencies with which it has data sharing agreements for verification and adjudication</p>

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>17. Eligibility determination must precede enrollment and is done separately.</p>	<p><i>Eligibility determination still proceeds enrollment but may be done in same process.</i></p>	<p><i>Both eligibility determination and enrollment in specific programs are handled simultaneously without redundant data.</i></p> <p><i>Services created for the enrollment process, including the Web application, the</i></p>	<p><i>Enrollment and eligibility determination processes are integrated with applications at the point of service – e.g., in schools when eligible for subsidized lunch and health programs; when applying for unemployment; when receiving public health services that result in certain diagnoses; or during a health care encounter with electronic health record systems, e.g., providers are alerted by their EHRs decision support systems that the patient’s data meets criteria for Medicaid program eligibility and prompts the provider to advise the patient.</i></p>	<p><i>purposes such as COB.</i></p> <p><i>Enrollment/eligibility determination processes are automated services triggered by point of service applications including PHRs and EHRs and run collaboratively. The enrollment/eligibility process (1) verifies information provided by the point of service application by calling federated registries, health record repositories and other data sources; (2) determines eligibility; (3) designs a member specific benefit package; (4) enrolls the member and provides the results via the point of service application.</i></p>
<p>18.</p>				

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>19. Enrollment in managed care and waiver programs requires cumbersome extension of traditional fee-for-service processes.</p> <p>20.</p>		<p>enrollment and verification interfaces, registry calls and synchronization mechanisms can be shared among states.</p>	<p>If the provider's system is service enabled, it can prepopulate appropriate enrollment application(s) and to request additional information needed from the provider/applicant.</p>	
<p>Cost-Effectiveness</p>				
<p>21. Requires a large staff to meet targets for manual enrollment of members.</p>	<p>Process requires fewer staff than Level 1 and produces better results.</p>	<p>Process requires fewer staff than Level 2 and improves on results.</p>	<p>Full automation of the process plus ability to auto/ad hoc query local person/patient registries reduces staff needed for verification, COB and fraud detection and improves cost savings.</p>	<p>More effective enrollment data exchange because information about all enrollment events of interest are pushed vs. querying potential sources of enrollment data.</p>
<p>22. Siloed enrollment processes</p>	<p>Fewer applicants and members</p>	<p>Shared services and inter-</p>		

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>23. <i>result in redundant infrastructure, effort and costs.</i></p>	<p><i>are enrolled erroneously, reducing program costs.</i></p>	<p><i>agency collaboration contribute to streamline the process.</i></p>	<p><i>Enrollment alerts to providers reduces staff needed for enrollment outreach and verification of health status.</i></p>	
<i>Accuracy of Process Results</i>				
<p>24. <i>Much of the application information is manually validated and verification may be difficult resulting in increase error rates and potential for fraud.</i></p> <p>25. <i>Decisions may be inconsistent.</i></p> <p>26.</p>	<p><i>Automation of business rules improves accuracy of validation and verification.</i></p> <p><i>Automated application of enrollment business rules improves consistency.</i></p> <p><i>Permits blending of program benefits to provide more appropriate services to members.</i></p>	<p><i>Automation of enrollment and verification data interchange improves timeliness and quality of data.</i></p> <p><i>Automated enrollment coordination of program benefits improves the members' access to appropriate services and compliance with state/federal law.</i></p>	<p><i>Ability to auto/ad hoc query federated registries to access enrollment and verification data increases data reliability and completeness, ensuring better process results.</i></p>	<p><i>Automated notification of enrollment events of interest further increases data reliability and completeness, ensuring better process results.</i></p>

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>27. Due to limited monitoring and re-verification of enrolled members' status, ineligible members may continue to be enrolled.</p> <p>28. MMIS and Contractor member registries are frequently not synchronized.</p>	<p>Standardization of enrollment data, verification automation, business rules and workflow capabilities, and coordination across programs enable monitoring and re-verification of enrolled members' status, reducing enrollment of ineligible members.</p> <p>Use of standardized, electronic enrollment transactions somewhat improves accuracy of enrollment data exchange between MMIS and Contractor member registries, but these may not be synchronized because of periodic batch updates.</p>	<p>Synchronization of eligibility and enrollment processes ensures data and decision consistency, thereby improving results.</p>		
<p><i>Utility or Value to Stakeholders</i></p>				
<p>29. Focus is on accurately processing enrollment and manually verifying information as efficiently as possible.</p>	<p>Automation and coordination of enrollment processes enable staff to focus more on enrolling members into the most appropriate program(s), and optimizing health, functional, cultural and linguistic appropriateness of benefits and providers for member satisfaction.</p>	<p>Members experience a seamless and efficient eligibility/enrollment process no matter how or where they contact the Agency. E.g., no redundant request for member data; no need to schedule appointments, greater ability to verify data online.</p>	<p>Applicants and providers are "pushed" information about and applications for potential eligibility/enrollment opportunities, automating member outreach.</p>	<p>Applicants are "presumptively eligiblized/enrolled" automatically at the point of care based on national verification of health and socio-economic data, ensuring immediate access to needed health care.</p>

ME Enroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>30. Staff does not have time to focus on health, functional, cultural and linguistic compatibility of provider or program for the member, or member satisfaction.</i></p>		<p><i>Members receive benefit packages (merged from all programs for which the member is eligible) specifically designed to meet individual's health, functional, cultural and linguistic needs</i></p>		

ME Disenroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>Most requests to disenroll member are received and responded to manually via phone, fax, USPS.</i></p>	<p><i>Requests to disenroll member are automated via AVRS, Web portal, EDI within an agency using agency standards for messages.</i></p>			
<p>2.</p>	<p><i>Responses to requests are immediate.</i></p>	<p><i>Responses are immediate.</i></p>	<p><i>Responses are immediate.</i></p>	<p><i>Turnaround time is immediate, on a national scale.</i></p>
<p>3.</p>		<p><i>Information can be shared among authorized entities within the state.</i></p>	<p><i>Information, including clinical, can be shared among authorized entities within the state.</i></p>	
<i>Data Access and Accuracy</i>				
<p>4. <i>Information is researched manually.</i></p>	<p><i>Automation improves access and accuracy.</i></p>	<p><i>Data inquiry messages use MITA standard interfaces, improving accuracy.</i></p>	<p><i>Medicaid Member Registries are federated with regional data exchange networks.</i></p>	<p><i>Medicaid Member Registries are federated with regional data exchange networks across the country and if desired, internationally.</i></p>
<p>5.</p>		<p><i>Collaborating agencies using the MITA standard interfaces can exchange data on members.</i></p>	<p><i>All authorized data exchange partners can access member information.</i></p>	
<p>6.</p>	<p><i>Access is via Web portal and EDI channels.</i></p>			

ME Disenroll Member: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
7. <i>There may be inconsistencies in responses.</i>				
<i>Effort to Perform; Efficiency</i>				
8. <i>Staff research and respond to requests manually.</i>	<i>Responses to requests to disenroll member are automated.</i>	<i>Provider information is continuously refreshed.</i>	<i>Access to clinical information is available.</i>	<i>Automated access to information nationally further improves efficiency.</i>
9.	<i>Fewer staff required to support.</i>	<i>Further reduction in staff support.</i>		
10.		<i>One stop shop for agencies who share members.</i>		
<i>Cost-Effectiveness</i>				
11. <i>Requires research staff.</i>	<i>Automation leads to fewer staff than Level 1.</i>	<i>Use of MITA standard interfaces streamlines the disenrollment process.</i>	<i>Regional, federated member registries eliminate redundant overhead, i.e., one-stop shop inquiries.</i>	<i>Gains of Level 4 are further improved by access to provider information on a national basis.</i>
12.	<i>Number of disenrollment requests per day increases significantly.</i>			
<i>Accuracy of Process Results</i>				
13. <i>Responses are manually validated, e.g., via call center audits; stakeholder satisfaction survey.</i>	<i>Automation improves accuracy of responses.</i>	<i>MITA standard interfaces produce consistent responses to requests.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	<i>Same as Level 4, on a national scale, where authorized.</i>

ME Disenroll Member: Business Capabilities¹

ME Disenroll Member: Business Capabilities ¹				
Level 1	Level 2	Level 3	Level 4	Level 5
14. Process complies with agency requirements.				
<i>Utility or Value to Stakeholders</i>				
15. Requesters receive the information they need.	Requesters receive immediate responses.	Requesters have a one-stop shop to access collaborating agencies to obtain information on a member.	Requesters benefit from access to clinical data as an added value.	Same as Level 4, on a national scale, where authorized.

ME Inquire Member Eligibility: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>Most requests for verification of member information are received and responded to manually via phone, fax, USPS.</i></p> <p>2.</p> <p>3.</p>	<p><i>Member eligibility/enrollment verification is automated via AVRS, point of service devices, Web portal, EDI, but remains siloed.</i></p> <p><i>Responses can be immediate.</i></p>	<p><i>Responses can be immediate.</i></p> <p><i>Information can be shared among entities authorized by the Agency.</i></p>	<p><i>Responses are immediate.</i></p> <p><i>Information, including clinical, can be shared among authorized entities within the RHIO.</i></p>	<p><i>Turnaround time is immediate, on a national scale.</i></p>
<i>Data Access and Accuracy</i>				
<p>4.</p> <p>5.</p>	<p><i>Automation improves access and accuracy.</i></p> <p><i>Access is via AVRS, point of service devices, Web portal, and EDI channels.</i></p>	<p><i>Member information is accessible from federated Member Registries within the state Enterprise. Member information is integrated via a Member Registry, which may either contain integrated records of member eligibility data or provide federated access to other Member Registries as appropriate.</i></p>	<p><i>Medicaid Member Registries are federated with RHIOs. All authorized data exchange partners can access member information.</i></p>	<p><i>Medicaid Member Registries are federated with regional data exchange networks across the country and if desired, internationally.</i></p>

ME Inquire Member Eligibility: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p>6. <i>There may be inconsistencies in responses. Media, data format and content differ by program.</i></p> <p>7. <i>Information is researched manually</i></p> <p>8.</p>	<p><i>Increased use of HIPAA eligibility/enrollment data but not the program and benefit data. Minimal use of these transactions for COB. Eligibility Verification Requests and Responses are communicated using HIPAA X12 270/271 and NCPDP Telecommunications Guide v 5.1 and Batch Guide v 1.0.</i></p>	<p><i>Member eligibility/enrollment, program, and benefit data and messaging formats adhere to MITA standard interfaces, improving verification, COB, reporting, and research accuracy. MITA standard interfaces incorporate full HIPAA data schemas.</i></p>	<p><i>Requests are expanded to include inquiries re clinical information. For example, a provider can query a Member Registry about the location of needed clinical records anywhere in the state.</i></p>	
<i>Effort to Perform; Efficiency</i>				
<p>9. <i>Staff research and respond to requests manually.</i></p>	<p><i>Responses to requests to verify member information are automated.</i></p>	<p><i>Member information is continuously refreshed.</i></p>	<p><i>Access to clinical information can improve efficiency for treatment, payment and operations.</i></p>	<p><i>Automated access to information nationally further improves efficiency.</i></p>

ME Inquire Member Eligibility: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p>10. High rate of erroneous eligibility information.</p> <p>11. Verification takes effort and too much time for providers. Providers often depend on paper member ID cards that can be inaccurate.</p> <p>12.</p> <p>13.</p>	<p>Electronic verification is easier and faster, so providers use it more often.</p> <p>Fewer staff required to support.</p> <p>The sources of eligibility information are siloed within different programs; member data is not integrated and not semantically interoperable across programs.</p>	<p>Providers increasingly use verification because centralized registry gives them access to all Agency eligibility information including programs and benefits.</p> <p>Further reduction in staff support.</p> <p>One stop shop for programs that share members. Sister agencies adopt MITA standard interfaces to present a one-stop shop for inquires regarding enrolled members.</p>	<p>Eligibility verification, program, benefit, and Member Registry health record locator services are integrated into applications such as EHRs and PHRs within RHIO(s) which enhances responses to inquiries regarding members.</p>	
<i>Cost-Effectiveness</i>				
<p>14. Requires research staff.</p>	<p>Automation leads to fewer staff than Level 1. Number of responses per day increases</p>	<p>Because covered services are included in eligibility verification responses,</p>	<p>Full automation of the process plus access to clinical data reduces staff requirements to a</p>	<p>Gains of Level 4 are further improved by access to member information on a national</p>

ME Inquire Member Eligibility: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p>15. Mailing id cards to members monthly is costly.</p> <p>16. Verification is too expensive for providers to use for each encounter but providers risk cost of denied claims for ineligible members and non-covered services.</p>	<p>significantly.</p> <p>Electronic verification lowers cost to providers and reduces denied claims for ineligible members and non-covered services.</p>	<p>providers experience fewer claim denials based on non-covered services.</p>	<p>core team of professionals who monitor stakeholder satisfaction with responsiveness to inquiries. Regional, federated provider registries eliminate redundant overhead.</p>	<p>basis.</p>
<i>Accuracy of Process Results</i>				
<p>17. Responses are manually validated, e.g., call center audits; stakeholder satisfaction survey.</p> <p>18. Process complies with agency requirements.</p>	<p>Automation improves accuracy of responses.</p>	<p>Business services standardize requests and responses nationally. More robust use of the HIPAA transactions increases accuracy.</p>	<p>Incorporation of clinical data improves accuracy of some responses.</p>	<p>Same as Level 4, on a national scale, where authorized.</p>
<i>Utility or Value to Stakeholders</i>				
<p>19. Requestors receive the</p>	<p>Providers have no delay in</p>	<p>Providers have a one stop shop</p>	<p>Some inquiries/responses are</p>	<p>Same as Level 4, on a national</p>

ME Inquire Member Eligibility: Business Capabilities

<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Level 5</i>
<i>information they need.</i>	<i>obtaining responses.</i>	<i>to access collaborating agencies to obtain information.</i>	<i>replaced by automated messaging.</i>	<i>scale, where authorized.</i>

ME Manage Applicant and Member Communication: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>Manual and semi-automated steps may require some days to complete response.</i></p>	<p><i>Member requests and responses are automated via Web, AVRS, EDI with date stamp and audit trail.</i></p>	<p><i>Inquiries can be made to multiple agencies via collaboration. Response can be immediate.</i></p>	<p><i>Turnaround time is immediate, including clinical data.</i></p>	<p><i>Turnaround time is immediate, on a national scale.</i></p>
<p>2.</p>	<p><i>Research and response for these standardized communications are immediate or within batch response parameters.</i></p>			
<i>Data Access and Accuracy</i>				
<p>3. <i>Responses are made manually and there may be inconsistency and inaccuracy (within agency tolerance level).</i></p>	<p><i>Automated responses increase accuracy.</i></p>	<p><i>Requests and responses are standardized nationally, improving accuracy.</i></p>	<p><i>Responses are standardized and can include clinical data.</i></p>	
<p>4.</p>	<p><i>Access is via Web portal and EDI channels.</i></p>	<p><i>Member information is accessed via either a single Member Registry or federated Member Registries.</i></p>	<p><i>Member Registries are federated with regional data exchange networks, improving access channels.</i></p>	<p><i>Member Registries are federated with regional data exchange networks across the country and if desired, internationally. Responses are immediately available.</i></p>
<p>5.</p>		<p><i>Member information belonging to different entities can be virtually consolidated to form a single view.</i></p>		

ME Manage Applicant and Member Communication: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
6.		<p><i>Agencies support deployment of internet access points, such as kiosks and low cost telecommunication devices such as cell phones for distribution to mobile communities, to alleviate communications barriers.</i></p> <p><i>Member communication is organized around the “no wrong door” concept, which ensures that regardless of point of entry, current and prospective members will be able to access information about all programs.</i></p>	<p><i>In addition to Level 3 gains, certain messages to members are triggered by an individual’s entries into personal health records for prospective and current members.</i></p>	<p><i>Member communications posted by an agency can be accessed by a member anywhere in the country.</i></p>
<i>Effort to Perform; Efficiency</i>				
<p><i>8. Staff research and respond to requests manually. Requests are received from members in non-standard formats.</i></p> <p><i>9. Member communications are primarily conducted via</i></p>	<p><i>Responses to member requests are automated.</i></p> <p><i>Member communications are primarily conducted via paper</i></p>	<p><i>Member communications are</i></p>		<p><i>Automated access to information nationally further improves efficiency.</i></p>

ME Manage Applicant and Member Communication: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>paper and phone. Most requests are sent via telephone, fax, or USPS.</i></p>	<p><i>and phone. However, states begin using Websites to provide member information on providers and health plans, and responses to inquiries that can be responded to online or by phone.</i></p>	<p><i>primarily electronic, with paper used only as needed to reach populations. Information requested by member is continuously refreshed.</i></p> <p><i>Collaboration among agencies achieves a one-stop shop for member inquiries, e.g., mental health member requests claim payment status from Medicaid, Mental Health Department, Community Health Center.</i></p>	<p><i>Access to clinical information improves efficiency.</i></p> <p><i>Information entered into provider electronic health records can also trigger specific messages to members regarding special programs and disease management information.</i></p>	
10.				
11.				
12.				
<i>Cost-Effectiveness</i>				

ME Manage Applicant and Member Communication: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
18.	<p><i>Member communications are linguistically, culturally, and competency appropriate, but require considerable manual intervention for paper communications.</i></p>	<p><i>Use of electronic communications makes provision of linguistically, culturally, and competency appropriate member communications more feasible and cost-effective.</i></p>		
19.			<p><i>Public health alerts can be triggered by clinical information in the patient's electronic health record.</i></p>	

ME Manage Member Grievance & Appeal: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>This is an all-manual process.</i></p> <p>2. <i>Confidential documents are transferred by certified mail.</i></p> <p>3.</p> <p>4. <i>Cases typically require months to complete.</i></p>	<p><i>Requests for member information are automated via AVRS, Web portal, EDI within an agency.</i></p> <p><i>Documents are scanned and the case file is automated and can be shared among case workers.</i></p> <p><i>Responses to research questions within the agency are immediate.</i></p> <p><i>Overall timeline to resolve a case is shortened.</i></p>	<p><i>Case file is Web-enabled; information is shared among staff managing the case.</i></p> <p><i>Responses to research questions are immediate across all data sharing partners within the state.</i></p>	<p><i>Responses to research questions are immediate. Information, including clinical, is immediately and directly accessible.</i></p>	<p><i>Turnaround time of information gathering is immediate, on a national scale.</i></p>
<i>Data Access and Accuracy</i>				
<p>5. <i>Information is researched manually.</i></p> <p>6.</p>	<p><i>Automation improves access and accuracy.</i></p> <p><i>Access is via Web portal and EDI channels.</i></p>		<p><i>Medicaid Member Registries are federated with regional data exchange networks.</i></p> <p><i>All authorized data exchange partners can access member information, including clinical data.</i></p>	<p><i>Medicaid Member Registries are federated with regional data exchange networks across the country and if desired, internationally.</i></p>

ME Manage Member Grievance & Appeal: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>7. <i>There may be inconsistencies in responses.</i></p> <p>8. <i>There are no standards for case data.</i></p>	<p><i>There is more consistency in the steps taken in the review and resolution process.</i></p> <p><i>Agency standards for inquiries are introduced.</i></p>	<p><i>Standard MITA interfaces improve accuracy of content.</i></p>		
<i>Effort to Perform; Efficiency</i>				
<p>9. <i>Staff research and maintain manually.</i></p> <p>10.</p> <p>11.</p>	<p><i>Responses to requests to verify member case information are automated.</i></p>	<p><i>MITA standard interfaces standards are used for creation of a case and publication of results.</i></p> <p><i>MITA standard interfaces are also used for inquiry and response for acquisition of information needed to build the case.</i></p>	<p><i>Access to clinical information improves efficiency. Clinical data is automatically accessed to substantiate case findings.</i></p> <p><i>The original case against a provider may be triggered directly from the clinical record. This is a paradigm shift that introduces a new business process.</i></p>	<p><i>Automated access to information nationally further improves efficiency.</i></p> <p><i>Case researchers instantly know if there are case precedents in other states or agencies (a) for the provider in question, or (b) for similar types of cases.</i></p>

ME Manage Member Grievance & Appeal: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
12.		<p><i>Medicaid collaborates with other health and human services agencies that manage appeals to create a one-stop shop model for both provider and consumer appeals.</i></p>	<p><i>Automated business rules that include clinical data lead to earlier resolution of cases.</i></p>	
<i>Cost-Effectiveness</i>				
<p>13. <i>Process is labor-intensive. Results take several months.</i></p> <p>14.</p> <p>15.</p>	<p><i>Automation of some research steps reduces level of staffing required to manage a case.</i></p>	<p><i>Collaboration with sister agencies that conduct appeals cases increases cost-effectiveness.</i></p> <p><i>Standardization of input and case results allows staff to focus on analytical activities.</i></p>	<p><i>Full automation of the process plus access to clinical data reduce staff requirements to a core team of professionals who monitor stakeholder satisfaction with responsiveness to inquiries.</i></p> <p><i>Regional, federated provider registries eliminate redundant overhead.</i></p>	<p><i>Gains of Level 4 are further improved by access to member information on a national basis.</i></p>
<i>Accuracy of Process Results</i>				

ME Manage Member Grievance & Appeal: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>16. Terms of the settlement or results of the hearing are manually documented according to the administrative rules of the state.</p> <p>17. There may be inconsistencies between similar cases. Process complies with agency requirements.</p>	<p>Automation is introduced into the case management process. Results are documented and recorded automatically and can be accessed and reviewed as needed.</p>	<p>MITA standard interface improves accuracy of case results.</p>	<p>Incorporation of clinical data improves accuracy of final disposition of the case.</p>	<p>Gains of Level 4 are further improved by access to member information on a national basis.</p>
<i>Utility or Value to Stakeholders</i>				
<p>18. Business process complies with agency and state requirements for a fair hearing and disposition.</p>	<p>The member and the agency benefit from introduction of automation to speed up the case resolution.</p>	<p>Agencies benefit from introduction of MITA standard interfaces. Members benefit from consistency and predictability of the process.</p>	<p>Use of clinical evidence reduces false positives and improves consistency of results.</p>	<p>Same as Level 4, on a national scale.</p>

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>Manual and semi-automated steps delay updates, maintenance processes and require system down-time.</i></p> <p>2.</p> <p>3. <i>Inadequate audit trails.</i></p>	<p><i>Timelier member updates and data extractions.</i></p>	<p><i>Updates and data extractions can be immediate.</i></p> <p><i>Data exchange partners receive update notifications instantly.</i></p>	<p><i>Turnaround time is immediate.</i></p> <p><i>Updates are available to all authorized data exchange partners.</i></p>	<p><i>Turnaround time is immediate, on a national scale.</i></p>
<i>Data Access and Accuracy</i>				
<p>4. <i>Updates are made to individual files manually.</i></p> <p>5. <i>Data issues: duplicate identifiers, discrepancies between data stores, and information quality and completeness.</i></p> <p>6. <i>Data is shared in batch on a scheduled or ad hoc basis.</i></p>	<p><i>Automated updates are made to individual files and databases. Databases may be relational.</i></p>	<p><i>Updates, notifications, and data extractions (e.g., MSIS eligibility reports and MCO enrollment rosters) are standardized.</i></p> <p><i>Member records are stored in either a single Member Registry or federated Member Registries that can be accessed by all authorized applications.</i></p>	<p><i>Medicaid Member Registries are federated with regional data exchange networks. Updates, notifications and data</i></p>	<p><i>Medicaid Member Registries are federated with regional data exchange networks across the country and if desired,</i></p>

ME Manage Member Information: Business Capabilities

ME Manage Member Information: Business Capabilities				
Level 1	Level 2	Level 3	Level 4	Level 5
			<i>extractions are accessible to all authorized data exchange partners.</i>	<i>internationally. Updates notifications are automatically sent to all authorized interested data exchange partners.</i>
<i>Effort to Perform; Efficiency</i>				
<p>7. <i>Staff must key new information; make updates manually; reconcile and validate data manually.</i></p>	<p><i>Updates are automatically processed. Edits are consistent.</i></p>	<p><i>Updates are distributed to data sharing partners.</i></p>	<p><i>Clinical data could be used to trigger member registry updates and to push member data to other applications, e.g., EHRs, Immunization registries; and care/disease management applications.</i></p>	<p><i>Any data exchange partner can send a notification regarding a member record update to any other program in the USA. Nationally interoperable validation sources automatically send notice of change in member enrollment and socio-economic status, eliminating the need to re-verify; supports fraud detection in real time anywhere in the USA.</i></p>
<p>8. <i>Legacy systems limit Agency's ability to start and end eligibility in MCOs within a month, thereby increasing cost of capitation premiums paid for members who become ineligible during the month.</i></p>	<p><i>MCO premiums are paid on a daily rate, lowering capitation premium costs for ineligible members.</i></p>	<p><i>One stop shop for entities who share members.</i></p>		

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
9.			<p><i>Ability to access clinical data electronically to calculate performance and outcome measures improves quality of care, care/disease management protocols, and program design.</i></p>	
<i>Cost-Effectiveness</i>				
<p><i>10. Requires numerous data entry staff to key new and updated information, and reconcile duplicates and data inconsistencies. IT staff needed to load member information generated from other systems.</i></p>	<p><i>Automation leads to fewer staff than Level 1.</i></p>	<p><i>Distributed update notifications to federated member registries reduces staff requirements.</i></p>	<p><i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who focus on performance and outcome measures; care/disease management; improves COB and fraud detection; and benefit package design to reduce program costs. Using clinical data electronically vs. paper charts lowers costs to calculate performance and outcome measures.</i></p> <p><i>Regional, federated member registries eliminate redundant overhead.</i></p>	<p><i>Gains of Level 4 are further improved by access to Member updates on a national basis. Optimizes performance and outcome measures; care/disease management; improves COB and fraud detection; and benefit package design, greatly reducing program costs.</i></p>
11.				
<i>Accuracy of Process Results</i>				

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p>12. Updates and reconciliations must be manually validated.</p> <p>13. Process focus is on compliance with agency requirements and less on ensuring timely availability of quality/complete data for users.</p>	<p>Automation improves accuracy of validation, verification, and reconciliation of database updates.</p>	<p>Member data is associated algorithmically to support federated access, automated updates, reconciliation and extraction of complete and quality data.</p>	<p>Automation and association of clinical data to member records improves accuracy of enrollment, performance measurement and care management processes.</p>	<p>National access to member enrollment/clinical data improves research, reporting, performance measures, outcome studies; care/disease management; and fraud detection.</p>
<p><i>Utility or Value to Stakeholders</i></p>				
<p>14. Member information is maintained and available, primarily on a scheduled or request basis to other business processes and users.</p> <p>15.</p>	<p>Automated maintenance of member information ensures that timely, accurate data are available to support all processes needing member information, e.g., MCO enrollment rosters, COB, adjudication, etc.</p>	<p>Member and staff satisfaction improves because data accessibility increases the efficiency, speed, and accuracy of eligibility/enrollment and other processes.</p>	<p>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</p> <p>Ability to access de-identified member clinical data electronically to calculate performance and outcome measures improves member and regional patient care.</p>	<p>Same as Level 4, on a national scale, where authorized.</p> <p>Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.</p>

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
	<p><i>members must spend discovering needed information.</i></p>			
<p><i>Data Access and Accuracy</i></p>				
<p>5. <i>Preparation of materials is clunky. Information is subject to inaccuracies and inconsistencies.</i></p>	<p><i>Automation improves access and accuracy. Increased standardization of administrative data, and improved data manipulation for decision support improves accuracy of population targeting.</i></p>	<p><i>Algorithmic identification of and analysis based on standardized data to targeted members improve in accuracy. Access to standardized electronic clinical data via registries, electronic prescribing, claims and service review attachments and electronic health records, as well as use of GIS and socio-economic indicators support targeting populations for outreach.</i></p>	<p><i>Access to standardized clinical data facilitates identification of targeted current and prospective members. Standardized services support application interfaces for electronic interchange of outreach and education materials to targeted members.</i></p>	<p><i>Outreach and education materials can be effectively pushed on an as needed basis because of standardized data used by Member Registries nationally. Standardized business process collaboration protocols support application interfaces for peer2peer outreach and education processes.</i></p>
<p>6.</p>	<p><i>Current and prospective members can access needed information via Web portal. Outreach materials are developed and stored in electronic format and made available to members via a Web portal, public media, or kiosks, somewhat improving current and prospective members' ability to locate</i></p>	<p><i>Member information is accessed via federated Member Registries that can be accessed by all authorized entities within the state. Agencies support deployment of internet access points, such as kiosks and low cost telecommunication devices such as cell phones for distribution to mobile</i></p>		

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p>7. <i>Lack of functionally, linguistically, culturally, and competency appropriate outreach and education materials likely limit members' access to information.</i></p> <p>8. <i>Mailings are not delivered because contract data in members' records do not meet NPS standards.</i></p>	<p><i>needed information.</i></p> <p><i>Increasing use of functionally, linguistically, culturally, and competency appropriate outreach and education materials improve members' access to information.</i></p>	<p><i>communities, to alleviate communications barriers</i></p> <p><i>Use of NPS standards for member data improves accuracy for mailing purposes.</i></p>		
<p><i>Effort to Perform; Efficiency</i></p>				
<p>9. <i>Staff develops and maintains materials manually.</i></p> <p>10. <i>Developing functionally, linguistically, culturally, and competency appropriate outreach and education materials is</i></p>	<p><i>Materials can be posted on a Web site for downloading by members.</i></p> <p><i>Delivery of functionally, linguistically, culturally, and competency appropriate outreach and education materials is eased with</i></p>	<p><i>Outreach and education materials are available via state Medicaid portal and are shared with other collaborating agencies.</i></p> <p><i>National standards are developed for creation education and outreach materials.</i></p>		<p><i>Outreach and education materials can be effectively pushed on an as needed basis regionally or nationally via federated Member Registries.</i></p>

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>difficult.</i></p> <p><i>11. As a result, more staff is required to assist members needing such material.</i></p> <p><i>12. Effort is required to research target current and prospective target populations and track mailings.</i></p>	<p><i>electronic and public media channels.</i></p> <p><i>Fewer staff required to support.</i></p> <p><i>Populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socio-economic status, functional and health needs based on increased standardization of administrative data, and improved data manipulation for decision support.</i></p>	<p><i>Further reduction in staff required for this business process.</i></p> <p><i>Business services are developed and shared nationally to support target population identification.</i></p>	<p><i>Access to clinical information improves efficiency by automatically mapping member who needs assistance with generation of appropriate materials.</i></p> <p><i>Automated business rules that include clinical data lead to faster identification of target populations.</i></p>	<p><i>The target population analysis based on real time access to health and socio-economic indicators drawn from standardized person/patient data. Peer2peer business process collaboration between the Agency and EHRs or other program applications, e.g., state Employment department system for tracking unemployed individuals, a PHR or EHR, trigger applications to collaboratively assist current and prospective members with outreach – e.g., pre-populating member data in an eligibility/enrollment application for an appropriate program and returning the determination/enrollment information in real time via the initiating application (No Wrong Application).</i></p>

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p>13. Mailings are not delivered because of inaccurate, nonstandard contact information, resulting in need to follow up with members by other means or missing outreach and education opportunities.</p>		<p>Mailings are more successful because member records have NPS standard data and member registries' use algorithmic identification to improve data accuracy, reducing the need to follow up with members by other means or missing outreach and education opportunities.</p>		
<i>Cost-Effectiveness</i>				
<p>14. Process is labor-intensive.</p>	<p>Automation reduces level of staffing required to target populations needing outreach and education.</p>	<p>Collaboration, data sharing, and shared services increase cost-effectiveness.</p>	<p>Full automation of the process of identification of need, mapping to the right message, plus access to clinical data reduces staff requirements to a core team of professionals who monitor the education and outreach process.</p>	<p>Outreach and education can be interoperable among states sharing business services, reducing redundant effort and optimizing delivery of appropriate needed material real time to the point of care.</p>
<p>15. Paper materials are expensive to produce. Incurs postal expenses and cost of undelivered mail.</p>	<p>Availability of online materials reduces paper and mailing costs.</p>	<p>Predominant use of electronic and public media communication channels lowers cost of paper materials and improves message delivery.</p>		
<p>16.</p>		<p>NPS standard member contact information decreases</p>		

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
17. Staff still needed where the materials are not appropriate for member.		undelivered mailings.		
<i>Accuracy of Process Results</i>				
18. Difficult to determine impact of outreach and education.	Use of portal by members is monitored to ensure that a sufficient number of the targeted populations are actively engaged in downloading information.	Business services standardize messages sent to members.	Incorporation of clinical data improves accuracy of identification of targeted members and dissemination of appropriate messages. Member registries improve accuracy of contact information.	Gains of Level 4 are further improved by access to member information on a regional or national basis.
19.	Agency can target members who are not accessing information.			
20. Current and prospective members continue to need assistance by phone.				
<i>Utility or Value to Stakeholders</i>				
21. Business process complies with agency and state requirements for educating the members regarding rules and regulations and how to communicate with	The members and the agency benefit from introduction of automation to speed up the outreach and education process.	Agencies benefit from sharing of the business service and information with other agencies. Members benefit from consistency and timeliness of the information	Outreach and education communications can be triggered by automated messaging. Use of clinical evidence creates better target groups and improves	Same as Level 4, on a regional or national scale.

ME Manage Member Information: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>the Agency.</i></p> <p>22. Functionally, linguistically, culturally, and competency appropriate outreach and education materials are lacking because difficult and costly to produce.</p>	<p><i>Outreach material is functionally, linguistically, culturally, and competency appropriate, but at great expense.</i></p>	<p><i>transmitted.</i></p> <p>Use of electronic communications makes provision of functionally, linguistically, culturally, and competency appropriate outreach material more feasible and cost-effective.</p>	<p><i>consistency of results.</i></p> <p>Staff focuses on maintaining a data base of functionally, linguistically, culturally, and competency appropriate outreach and education materials.</p>	

Operations Management

OM1 Authorize Service: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines.</i></p> <p><i>Decisions may take several days.</i></p>	<p><i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i></p> <p><i>Decisions take less time than level 1.</i></p>	<p><i>Optimizing automation improves error rates and timeliness, thereby enabling support of real-time processing.</i></p>	<p><i>As the provider enters service data into the CLINICAL DATA, authorization is immediately established by the payer application.</i></p>	<p><i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.</i></p>
<i>Data Access and Accuracy</i>				
<p>2. <i>Authorize Service request is primarily paper, phone or fax based.</i></p>	<p><i>Authorize Service request is a mix of paper/phone/fax and EDI.</i></p>	<p><i>The Agency receives EDI transactions via electronic means that support even small, rural, and waiver providers.</i></p>	<p><i>Service authorization is embedded in the provider to payer system communication.</i></p>	
<p>3. <i>Format and content are not HIPAA compliant.</i></p>	<p><i>The Authorize Service requests are increasingly compliant with HIPAA. However, HIPAA companion guides may still require data based on state-specific business rules.</i></p>	<p><i>All programs, even those, such as waiver programs that are not covered under HIPAA, use semantically interoperable data in the process.</i></p>	<p><i>The Medicaid agency and providers establish pointers to repositories of member's clinical data. This data takes the form of virtual records used to inform the Authorize Service process.</i></p> <p><i>Meta-data is used to locate the records and to ensure semantic interoperability of the data</i></p>	

OM1 Authorize Service: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
			<i>even where the data may be based on different coding schemes or data models.</i>	
<i>4. Inflexibility in Authorize Service processing is a key factor in the proliferation of siloed systems outside of the MMIS, especially for waiver programs that determine medical appropriateness and service authorization differently than traditional Medicaid programs. As a result, data is not comparable across silos.</i>	<i>Waiver Authorize Service data continue to be submitted to siloed payment systems using state specific format and data, such as provider type and service codes. As a result, data continues to lack comparability across silos.</i>	<i>Standardized data and Authorize Service rules enable tracking of over-utilization of similar services that are coded differently for prospective program integrity and tracking contraindication of services provided for medical appropriateness. As a result, all siloed payment systems are integrated; saving resources and optimizing FFP; and data quality is improved.</i>		
<i>5. Authorize Service request is primarily paper, phone or fax based.</i>	<i>Requests may be accepted by internet Web portals, email, dial-up, and via transferable electronic media such as disks and tape. This increases the number of small providers who can submit Authorize Service requests electronically.</i>	<i>Web portals support error free submissions with data field masks, client-side edits, and pre-populated fields, thereby eliminating the need for these submissions to go through manual validation.</i>		
<i>6.</i>			<i>Preconditions for achieving this level are use of established RHIOs and semantic interoperability.</i>	<i>Same capabilities as Level 4 expanded to a national base of data via the NHIN. The Authorize Service process</i>

OM1 Authorize Service: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
				<i>queries national registries for pointers to repositories of member's clinical data stored anywhere in the country.</i>
<i>Effort to Perform; Efficiency</i>				
<i>7. Information is manually validated and manually transferred from submitted paper to the MMIS.</i>		<i>The Authorize Service process is completely automated and only rare exceptions must be manually reviewed.</i>		
<i>8. If an Authorize Service request requires additional information, the reviewer must manually contact the submitter/provider, which delays processing and is resource intensive.</i>	<i>Authorize Service processes generate an electronic request for additional information via an X12 277 if additional information is required.</i>		<i>Direct access to Clinical data eliminates the need for additional information within the Authorize Service process.</i> <i>The Authorize Service process is an inter-enterprise business process between Medicaid systems and Clinical data during an episode of care eliminating the need for providers to submit Authorize Service requests or supporting clinical data.</i>	
<i>9.</i>		<i>Related processes are decoupled, allowing changes to be made in the Authorize Service process with reduced potential for unintended</i>		

OM1 Authorize Service: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
		<i>downstream processing consequences.</i>		
<i>Cost-Effectiveness</i>				
<i>10. Since these systems duplicate MMIS capabilities and do not meet current MMIS requirements, states lose development, design, and implementation as well as operational federal funding participation (FFP).</i>	<i>Maintenance continues to be expensive and time-consuming.</i>	<i>Due to increased efficiency, staff can be redirected to more productive tasks</i>	<i>Full automation of the process plus access to clinical will refocus staff on performance outcomes; care management; stakeholder satisfaction.</i>	
<i>Accuracy of Process Results</i>				
<i>11. Authorize Service requests are primarily manually validated against state-specific business rules. As a result, states may conduct Authorize Service retrospectively as an audit, missing opportunities to ensure appropriate use of services.</i>	<i>Only unstructured paper forms are used in a manual review process, so inconsistent interpretation and application of Authorize Service rules persist. The increasing centralization of business processes promotes harmonized rules across some silos.</i>	<i>Authorize Service process uses complex algorithms and the application of structured clinical data so that both prospective program integrity and medical appropriateness can be highly automated, improving the consistency and correctness of the decisions.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	
<i>12. Related processes are tightly integrated, making it difficult to ensure that changes to service authorization process do not result in unintended cross-process</i>	<i>Despite progress, related processes continue to be tightly integrated, resulting in difficulty in making changes to business rules.</i>	<i>Authorize Service processing is highly flexible so that rule changes can be made quickly and inexpensively in response to need for new or different rules.</i>		

OM1 Authorize Service: Business Capabilities¹

OM1 Authorize Service: Business Capabilities ¹				
Level 1	Level 2	Level 3	Level 4	Level 5
<i>consequences.</i>				
<i>Utility or Value to Stakeholders</i>				
<i>13. Business process complies with agency and state requirements</i>	<i>The agency benefit from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Through peer-to-peer collaboration, the CLINICAL DATA assists the provider with Medicaid clinical protocols required for coverage, such as diagnoses, functional or health status, or clinical test results.</i>	<i>Through peer-to-peer collaboration, the CLINICAL DATA assists the provider with Medicaid clinical protocols required for coverage, such as diagnoses, functional or health status, or clinical test results, on a national level.</i>

OM1 Authorize Treatment Plan: Business Capabilities

Authorize Treatment Plan				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Descriptions				
<p>At this level, the <i>Authorize Treatment Plan</i> process is performed primarily using a paper/phone/fax process. Review of authorization of treatment plan requests are performed manually which is resource intensive, untimely and may result in inconsistent:</p> <ul style="list-style-type: none"> ■ Application of business rules ■ Communication of errors to providers ■ Decisions on the need for or sufficiency of additional information <p>If the treatment plan request requires additional information, the reviewer must manually contact the submitter/provider, which delays processing and is resource intensive. Format and content is not standardized and is likely state-specific. The requests are primarily manually validated against state-specific business rules. However, when there is automated validation, rules</p>	<p>At this level, the <i>Authorize Treatment Plan</i> process is a mix of paper/phone/fax and EDI. The authorize treatment plan requests may be accepted by internet Web portals, email, dial-up, and via transferable electronic media such as disks and tape. This increases the number of small providers who can submit requests electronically. If a treatment plan data set fails review, rather than the reviewer having to manually contact the submitter, the process can now generate an electronic request for additional information via an X12 277.</p>	<p>At this level, the <i>Authorize Treatment Plan</i> process transaction receives only EDI transactions via electronic means that support even small, rural, and waiver providers. Web portals support error free submissions with data field masks, client-side edits, and pre-populated fields. Standardized data enable tracking of over-utilization of similar services that are coded differently for prospective program integrity and tracking contraindication of services provided for medical appropriateness.</p>	<p>At this level, the <i>Authorize Treatment Plan</i> process queries national and regional registries for pointers to repositories of member's EHRs for clinical data and provider credentialing and sanction data for prospective program integrity audits. This data takes the form of virtual records. Meta-data is used to locate the records and to ensure semantic interoperability of the data even where the data may be based on different coding schemes or data models. Real-time access to source data ensures accuracy and improves process performance. This also enables enhanced business activity monitoring is based on optimal data streams to fine-tune business process rules to meet operational parameters, thereby ensuring that Agency objectives are met.</p>	<p>At this level, the <i>Authorize Treatment Plan</i> process is a simplified process. Inter-enterprise business process management between Medicaid systems and Clinical data during an episode of care eliminates the need for providers to submit treatment plan data. Through peer-to-peer collaboration, member and provider data accessible in regional registries are recognized by all participating applications as the "source of truth" – eliminating the necessity for the provider to send this information and for the Audit process to validate against its version of the information; the assists the provider with medical necessity protocols required by Medicaid and other payers' payment rules. Treatment plans for claims no longer needs to be checked because Medicaid business rules alert the provider about clinical prerequisites for service</p>

OM1 Authorize Treatment Plan: Business Capabilities

Authorize Treatment Plan				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>lack flexibility and are costly to change. Therefore, when new programs or code sets are added, the authorize treatment plan review validation may need to be accomplished manually. Inflexibility in review processing is a key factor in the proliferation of siloed systems outside of the MMIS, especially for waiver programs that determine medical appropriateness and authorize treatment plans differently than traditional Medicaid programs. As a result, data is not comparable across silos. Since these systems duplicate MMIS capabilities and do not meet current MMIS requirements, states lose development, design, and implementation as well as operational federal funding participation (FFP). Related processes, including the <i>Edit Claim/Encounter</i>, <i>Audit Claim/Encounter</i>, <i>Price Claim/Value Encounter</i>, <i>Receive Inbound Transaction</i>, and <i>Send Outbound Transaction</i> processes are tightly integrated, making it</p>				<p>coverage, such as diagnoses, functional or health status, or clinical test results. Likewise, MCO use of authorize treatment plan can be monitored for underutilizations by review of the encounter data in the managed care members' Clinical data. Preconditions for achieving this level are use of established RHIOs and semantic interoperability.</p>

OM1 Authorize Treatment Plan: Business Capabilities

Authorize Treatment Plan				
Level 1	Level 2	Level 3	Level 4	Level 5
difficult to ensure that changes to service authorization process do not result in unintended cross-process consequences. Maintenance is expensive and time-consuming.				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM2 Apply Mass Adjustment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines.</i>	<i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i> <i>Decisions take less time than level 1.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i> <i>Turnaround time can be immediate.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service.</i>
<i>Data Access and Accuracy</i>				
2. <i>The agency identifies the claims to be adjusted, sets the parameters, and applies the retroactive rates through primarily manual processes.</i>	<i>Identification of claims to be adjusted and application of the adjustment are automated with audit trail.</i>	<i>MITA standard interfaces for mass adjustments are used by the state Medicaid agency.</i>	<i>Business process interfaces with other processes via federated architectures.</i>	
3. <i>Inconsistent data and format in process.</i>	<i>Adjustment data is specific to the agency.</i>	<i>Data and format are standardized via MITA standard interfaces and include clinical data.</i>		
<i>Effort to Perform; Efficiency</i>				
4. <i>Large numbers of mass adjustments are necessary.</i>	<i>Improvements throughout the Medicaid program operations reduce the number of mass adjustments required.</i>	<i>Effort to perform is reduced and efficiency is increased through state and regional data exchange, collaboration, adoption of data standards.</i>	<i>Business processes are transformed and efficiency is optimized through integration of <u>clinical data</u>.</i>	
5.		<i>The process has the flexibility to easily change the criteria for identification of claims and</i>		

OM2 Apply Mass Adjustment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
		<i>application of the adjustment.</i>		
6.		<i>Other agencies that might be affected by the mass adjustment collaborate with the Medicaid agency.</i>		
<i>Cost-Effectiveness</i>				
<i>7. Large number of staff required to perform business process.</i>	<i>Less staff required to perform business process. Automation leads to fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	
<i>Accuracy of Process Results</i>				
<i>8. Programs create inconsistent rules across the Agency and apply their own rules inconsistently.</i>	<i>More consistency in rule creation and application.</i>	<i>Rules are consistently applied.</i>		
<i>Utility or Value to Stakeholders</i>				
<i>9. Business process complies with agency and state requirements</i>	<i>The agency benefits from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

OM2 Apply Mass Adjustment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
10. <i>Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines.</i>	<i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i> <i>Decisions take less time than level 1.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i> <i>Turnaround time can be immediate.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service.</i>
<i>Data Access and Accuracy</i>				
11. <i>The agency identifies the claims to be adjusted, sets the parameters, and applies the retroactive rates through primarily manual processes.</i>	<i>Identification of claims to be adjusted and application of the adjustment are automated with audit trail.</i>	<i>MITA standard interfaces for mass adjustments are used by the state Medicaid agency.</i>	<i>Business process interfaces with other processes via federated architectures.</i>	
12. <i>Inconsistent data and format in process.</i>	<i>Adjustment data is specific to the agency.</i>	<i>Data and format are standardized via MITA standard interfaces and include clinical data.</i>		
<i>Effort to Perform; Efficiency</i>				
13. <i>Large numbers of mass adjustments are necessary.</i>	<i>Improvements throughout the Medicaid program operations reduce the number of mass adjustments required.</i>	<i>Effort to perform is reduced and efficiency is increased through state and regional data exchange, collaboration, adoption of data standards.</i>	<i>Business processes are transformed and efficiency is optimized through integration of <u>clinical data</u>.</i>	
14.		<i>The process has the flexibility to easily change the criteria for identification of claims and</i>		

OM2 Apply Mass Adjustment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
		<i>application of the adjustment.</i>		
15.		<i>Other agencies that might be affected by the mass adjustment collaborate with the Medicaid agency.</i>		
<i>Cost-Effectiveness</i>				
<i>16. Large number of staff required to perform business process.</i>	<i>Less staff required to perform business process. Automation leads to fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	
<i>Accuracy of Process Results</i>				
<i>17. Programs create inconsistent rules across the Agency and apply their own rules inconsistently.</i>	<i>More consistency in rule creation and application.</i>	<i>Rules are consistently applied.</i>		
<i>Utility or Value to Stakeholders</i>				
<i>18. Business process complies with agency and state requirements</i>	<i>The agency benefits from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

OM2 Edit and Audit Claim/Encounter: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. Suspended claims require lengthy manual resolution.</p>	<p><i>Electronic claim processing and POS adjudication greatly increase timeliness.</i></p>	<p><i>Turnaround time can be immediate.</i></p>	<p><i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i></p>	<p><i>(TBD)</i></p>
<i>Data Access and Accuracy</i>				
<p>2. The agency receives paper claims, EDI transactions, and POS conforming to <u>state</u> standards. Paper transactions are batched and scanned (or data entered).</p>	<p><i>The agency continues to accept paper claims, but most providers submit claims via Web portals, email, dial-up, POS, and EDI.</i></p>	<p><i>The agency continues to accept paper claims from a small number of disadvantaged providers, but the majority of transactions are submitted electronically.</i></p>		<p><i>the CLINICAL DATA assists the provider with coding and data required by Medicaid and other payers' payment rules, alerts the provider about clinical prerequisites for service coverage, such as diagnoses, functional or health status, or clinical test results.</i></p>
<p>3. Claims/encounter EDI format and content is not HIPAA compliant.</p>	<p><i>Electronic transactions meet HIPAA data standards. Payer Implementation Guides impose additional payer-specific rules.</i></p>	<p><i>Electronic transactions meet MITA standard interfaces.</i></p>		
<p>4. State-specified data elements trigger the Edit and Audit Claim/Encounter business process. For EDI claims/encounters, edits are automated for many steps, but are manual for</p>	<p><i>Translators convert national data standards to state-specific data to support business processes.</i></p>	<p><i>The Edit and Audit Claim/Encounter business process uses MITA standard data and therefore no translation is required.</i></p>		

OM2 Edit and Audit Claim/Encounter: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>attachments and suspended claims/encounters</i></p> <p>5. <i>Encounter data is received via tape in state-specified format and data content.</i></p> <p>6. <i>Sister agencies and waiver programs manage their own Edit and Audit Claim process.</i></p>	<p><i>Encounter data is received electronically or is posted to Web sites and uses state specified, non-HIPAA-compliant formats.</i></p> <p><i>Medicaid agency can accept sister agency and waiver program claims and load other agency data into an enterprise data warehouse by supporting multiple formats and mapping non-standard data elements.</i></p>	<p><i>Encounters are submitted as HIPAA compliant COB claims from managed care organizations and any other external processor, e.g., a PBM, mental health, dental processor, or other agency. Encounter data meets MITA standard interface requirements.</i></p> <p><i>Medicaid agency coordinates with other sister agencies and waiver programs to accept, process, and access MITA standard data elements.</i></p>	<p><i>Real-time access to source data ensures accuracy and improves process performance.</i></p>	<p><i>Access to additional data from national sources adds to accuracy of editing.</i></p> <p><i>Through peer-to-peer collaboration, member and provider data accessible in regional registries are recognized by all participating applications as the “source of truth” – eliminating the necessity for the provider to send this information and for the Edit process to validate against its version of the information;</i></p>

OM2 Edit and Audit Claim/Encounter: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>7. <i>As a result, data are not comparable across silos.</i></p> <p>8.</p> <p>9. <i>Attachment data is unstructured; it is difficult for reviewers to consistently interpret and apply adjudication rules.</i></p>	<p><i>However, waiver claims continue to be submitted to siloed payment systems using state specific format and data, such as provider type and service codes.</i></p> <p><i>As a result, data continues to lack comparability across silos.</i></p>	<p><i>All programs, even those not covered under HIPAA, use semantically interoperable data in the edit process.</i></p>	<p><i>Direct connection between Medicaid systems and providers' Clinical data during an episode of care eliminates the need for providers to submit claim data or attachments requiring editing.</i></p>	<p><i>Preconditions for this achieving this level are use of established RHIOs and semantic interoperability.</i></p>
<p><i>Effort to Perform; Efficiency</i></p>				
<p>10. <i>For EDI claims/encounters, edits are automated for</i></p>	<p><i>If a claim/encounter data set fails edit validation, the</i></p>	<p><i>Standardized data and edit rules enable tracking of</i></p>	<p><i>Claim processing is replaced by direct communication between</i></p>	

OM2 Edit and Audit Claim/Encounter: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>many steps, but are manual for attachments and suspended claims/encounters</i></p> <p>11. Inflexibility in Edit processing is a key factor in the proliferation of siloed payment systems outside of the MMIS, especially for waiver programs that determine member eligibility, enroll providers and pay for services differently than traditional Medicaid programs.</p> <p>12.</p> <p>13. COB is conducted by denying claims using the resource intensive payer-to-provider model.</p> <p>14. Edited fields are validated</p>	<p><i>process can now generate an electronic request for corrections via an X12 276.</i></p>	<p><i>overutilization of similar services that are coded differently for disallowance.</i></p> <p><i>Edit processing is highly flexible so that edit rules and code set changes can be made quickly and inexpensively. b Edit rules engines support complex algorithms so that benefit packages can be customized for members eligible for multiple programs. Edits can be structured for both traditional and waiver programs.</i></p> <p><i>As a result, all siloed payment systems are integrated or retired, saving resources and optimizing FFP; and data quality is improved.</i></p>	<p><i>provider system and payer system.</i></p> <p><i>This business process queries national and regional registries for member and provider information, thereby obtaining more definitive and extensive source data, especially relating to member third party resources because all known payers will be listed in the members' records.</i></p>	

OM2 Edit and Audit Claim/Encounter: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>against standard and state-specific code sets.</i></p> <p>15.</p> <p>16.</p> <p>17.</p>	<p><i>Although data is electronic, much of the review and verification of information must be done manually. If additional information is required, an electronic request is made, e.g., via an X12 277.</i></p>		<p><i>The Edit process, using repository meta-data in the registry records, is also able to locate and query the members' Clinical data to validate health status data in order to ensure the appropriate coding of services and reduce the need for suspending claims/encounters for additional information.</i></p> <p><i>In addition, the Edit process can locate members' primary payers' benefit repository, using pointers in the members' records, to access services covered under each third party resource, thereby validating service coverage to conduct COB more efficiently.</i></p>	

OM2 Price Claim/Value Encounter: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
19. <i>Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines.</i>	<i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i> <i>Decisions take less time than level 1.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i> <i>Turnaround time can be immediate.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service.</i>
<i>Data Access and Accuracy</i>				
20.			<i>Adjustment process (TBD).</i>	<i>The agency uses the NHIN to compare and select prices based on regional averages or other new pricing methodologies (TBD).</i>
21. <i>Standard Medicaid services are automatically priced using rate and fee reference data.</i>	<i>Pricing formulas are agency-specific.</i>	<i>Medicaid agency coordinates with sister agencies and waiver programs to present a one-stop shop claim adjudication and pricing process.</i>	<i>Pricing is embedded in the provider to payer system communication.</i>	<i>Supports regional pricing profiles that can be factored into the pricing methodology, e.g., a new pricing rule: "Pay the amount billed or the regional average (Region = ME, NH, VT), whichever is lower"... or, "Pay the regional per diem no matter what is billed".</i>
22. <i>Values are assigned to services reported on encounters, using the same reference data.</i>			<i>As the provider enters service data into the clinical record, authorization and pricing are immediately established by the</i>	

OM2 Price Claim/Value Encounter: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
			<i>payer application.</i>	
<i>23. "By-report" pricing is performed manually. This manual process is often used to accommodate changes in policy and pricing.</i>	<i>More services are automatically priced and there are fewer "by-report" manual pricing exceptions.</i>	<i>The agency uses MITA standard interfaces to price claims and value encounters.</i>		
<i>24. Waiver program and a-typical provider services are manually priced.</i>	<i>State Medicaid agency can support payment of waiver program and a-typical providers.</i>			
<i>Effort to Perform; Efficiency</i>				
<i>25. Staff manually prepare adjustment transactions including application of member contributions, provider advances, deduction of liens and recoupments.</i>	<i>Most single claim adjustments are automated.</i>	<i>Updates are distributed to data sharing partners. Distributed update notifications to federated registries.</i>	<i>Data triggers registry updates and pushes data to other applications (eg, EHRs, Immunization registries; and care/disease management applications)</i>	
<i>Cost-Effectiveness</i>				
<i>26. Maintenance is expensive and time-consuming.</i>	<i>Maintenance continues to be expensive and time-consuming.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	

OM2 Price Claim/Value Encounter: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
			<i>Agency transforms operations from labor intensive to strategic planning.</i>	
<i>Accuracy of Process Results</i>				
<i>27. Processes tightly integrated, making it difficult to ensure that changes to price claim process do not result in unintended cross-process consequences.</i>	<i>Despite progress, related processes continue to be tightly integrated, resulting in difficulty in making changes to business rules.</i>	<i>Flexible business rules allow maximum flexibility in changing pricing algorithms.</i>	<i>Use of clinical data will improve consistency of results</i>	
<i>Utility or Value to Stakeholders</i>				
<i>28. Stakeholders: the provider, the member, the care manager, agency staff; other agency; other payer; government; the public. (Stakeholders addressed as efficiently as required)</i>	<i>Automation and coordination processes enable staff to focus more on member and provider management.</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

OM3 Prepare Explanation of Benefits: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines.</p> <p>Decisions may take several days.</p>	<p>Process time is faster than level 1 because of Web portal, EDI, or other automated form.</p> <p>Timeliness exceeds legal requirement.</p> <p>Decisions take less time than level 1.</p>	<p>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</p> <p>Turnaround time can be immediate.</p>	<p>Process time is immediate. Clinical data is available in real time.</p>	<p>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.</p>
<i>Data Access and Accuracy</i>				
<p>2. Medicaid agency complies with federal regulations to produce random samples of EOMBs quarterly and mail to members.</p>	<p>Medicaid agency enhances the sampling process to target selected populations.</p>	<p>The agency uses MITA standard interfaces for the EOMB.</p>		
<p>3. Members are asked to read the EOMB and report on any discrepancies.</p>	<p>Member responses are automatically tabulated.</p>			
<p>4. Sensitive services are suppressed.</p>				
<p>5. Programs are siloed so uncoordinated.</p>	<p>Agencies are centralizing common processes to</p>	<p>Other agencies collaborate with Medicaid in the EOMB</p>	<p>EOMB is replaced by a Personal Health Record. The</p>	<p>Personal Health Records are accessible anywhere in the</p>

OM3 Prepare Explanation of Benefits: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
	<i>achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.</i>	<i>process.</i>	<i>agency has access to clinical data and can directly analyze services recorded and reported. The agency can communicate with individuals who appear to need special attention.</i>	<i>U.S. via the NHIN.</i>
<i>Effort to Perform; Efficiency</i>				
<i>6. Updates are completed (keyed) manually</i>	<i>Business processes that result in cost management are enhanced.</i>	<i>All EOB is coordinated among data sharing partner agencies in the state.</i>	<i>Business processes are transformed and efficiency is optimized through integration of clinical data.</i>	
<i>Cost-Effectiveness</i>				
<i>7. Maintenance is expensive and time-consuming. Inconsistent application of rules, delays, and labor intensive efforts.</i>	<i>Maintenance of EOB processes continues to be labor intensive.</i>	<i>Agencies adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally all of which improve cost-effectiveness.</i>	<i>Integration of clinical data stimulates a quantum leap in cost-effective results.</i>	
<i>Accuracy of Process Results</i>				
<i>8. Data issues with duplication,</i>	<i>Automation improves error rates.</i>	<i>Optimizing automation improves error rates and</i>	<i>Real-time access to source data ensures</i>	

OM3 Prepare Explanation of Benefits: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>discrepancies between data stores, and information quality and completeness.</i>		<i>timeliness of this process.</i>	<i>accuracy and improves process performance.</i>	
<i>Utility or Value to Stakeholders</i>				
<i>9. Cultural and linguistic adaptations do not exist.</i>	<i>Cultural and linguistic adaptations are introduced.</i>			
<i>10. The business process meets the stated targets of the agency. The agency uses reports to manage operations</i>	<i>Cost management programs are implemented that bring also bring value to stakeholders: i.e., members enrolled in managed care and PCP programs receive better attention for preventive care and treatment.</i>	<i>Level 3 focuses on building Member, Provider, and Medicaid Operations business services. Stakeholders will experience increased satisfaction in the way their needs are met. The administrative burden is lightened.</i>	<i>Integration of clinical data provides the most measurable increase in value that we can envision at this time. Use of clinical data improves most major business processes. Member and Provider stakeholders are empowered to participate in decision making. The agency</i>	<i>Level 5 consolidates the value gains of previous levels by reaching out to national data sources.</i>

OM3 Prepare Explanation of Benefits: Business Capabilities¹

<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Level 5</i>
			<i>can shift its attention to strategic planning and evaluation.</i>	

OM3 Prepare Provider EFT/Check and Prepare Premium/Capitation EFT/Check: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>11. <i>Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines.</i></p> <p><i>Decisions may take several days.</i></p>	<p><i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i></p> <p><i>Decisions take less time than level 1.</i></p>	<p><i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i></p> <p><i>Turnaround time can be immediate.</i></p>	<p><i>Process time is immediate. Clinical data is available in real time.</i></p>	<p><i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies.</i></p>
<i>Data Access and Accuracy</i>				
<p>12. <i>Medicaid agency or Department of Finance produces the <u>EFT transaction or a paper check using Medicaid agency or state DOF standards</u> for format and data content.</i></p>	<p><i>Medicaid agency complies with <u>state or industry standards for EFT transactions</u> and conforms with <u>HIPAA where appropriate</u>. Agency encourages electronic billers to adopt EFT payment.</i></p>	<p><i>The agency uses MITA standard interfaces for EFT transactions. Paper checks are produced where required for exceptional circumstances.</i></p>	<p><i>Payments are made directly to provider bank accounts triggered by entries into clinical records maintained by the provider and accessed by the payer.</i></p>	<p><i>EFT payments are distributed to any location in the country via the NHIN.</i></p>
<p>13. <i>Programs are siloed so uncoordinated.</i></p>	<p><i>Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.</i></p>	<p><i>All electronic billers receive EFT payment. Through inter-agency coordination, multiple agencies share the same EFT process.</i></p>	<p><i>Premium payments are made directly to MCO, insurance company, Medicare buy-in, et al bank accounts based on enrollment information.</i></p>	

OM3 Prepare Provider EFT/Check and Prepare Premium/Capitation EFT/Check: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Effort to Perform; Efficiency</i>				
14. Verification is manual and if difficult then may require a longer amount of time.	Verification is mostly automated.	Verification is fully automated and immediate. Automated verification and application response are real time.	Internal and regional person/patient registries and other enrollment data sources can be auto/ad hoc queried for changes in verification or enrollment status.	
<i>Cost-Effectiveness</i>				
15. Maintenance is expensive and time-consuming. Inconsistent application of rules, delays, and labor intensive efforts.	Maintenance of EOB processes continues to be labor intensive.	Agencies adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally all of which improve cost-effectiveness.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.	
<i>Accuracy of Process Results</i>				
16. Difficult to change business rules.	Despite progress, related processes continue to be tightly integrated, resulting in difficulty in making changes to business rules.	The agency has the flexibility to easily change the business rules.	Self adjusting business rules.	
<i>Utility or Value to Stakeholders</i>				
17. Business process complies with agency and state requirements	The agency benefits from introduction of automation	Agencies benefit from sharing of the business service and information with other agencies.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease	

OM3 Prepare Provider EFT/Check and Prepare Premium/Capitation EFT/Check: Business Capabilities¹

<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Level 5</i>
			<i>management.</i>	

OM3 Prepare Remittance Advice/Encounter Report: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines</p>	<p><i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i></p> <p><i>Decisions take less time than level 1.</i></p>	<p><i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i></p> <p><i>Turnaround time can be immediate.</i></p>	<p><i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i></p>	<p><i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service.</i></p>
<i>Data Access and Accuracy</i>				
<p>2. Medicaid agency produces the paper Remittance Advice using state Medicaid agency-specific format and data content.</p>	<p><i>Medicaid agency continues to provide paper RAs to providers who are not electronic billers.</i></p>	<p><i>The agency uses MITA standard interfaces for the RA. Paper RAs are still supported on an exception basis.</i></p>	<p><i>With provider clinical system to payer system communication, the RA is replaced by a new accounting mechanism, (TBD).</i></p>	<p><i>Payment information can be sent to any location in the country via the NHIN.</i></p>
<p>3. The RA itemizes the services that are covered in the payment and explains which services are not being paid or are being changed and the reason why. Explanations of codes are comprehensive and agency-specific.</p>				
<p>4. Medicaid agency produces the paper Remittance Advice using state Medicaid agency-specific format and data content.</p>	<p><i>The agency complies with HIPAA to supply an electronic RA that meets state agency Implementation Guide requirements.</i></p>	<p><i>All electronic billers receive ERAs.</i></p>		

OM3 Prepare Remittance Advice/Encounter Report: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
5. <i>Programs are siloed so uncoordinated.</i>	<i>Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.</i>	<i>Through inter-agency coordination, multiple agencies can use the same ERA data standard.</i>		
<i>Effort to Perform; Efficiency</i>				
6. <i>Verification is manual and if difficult then may require a longer amount of time.</i>	<i>Verification is mostly automated.</i>	<i>Verification is fully automated and immediate. Automated verification and application response are real time.</i>	<i>Data triggers registry updates and pushes data to other applications</i>	
<i>Cost-Effectiveness</i>				
7. <i>Large number of staff required to perform business process.</i>	<i>Less staff required to perform business process. Automation leads to fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	
<i>Accuracy of Process Results</i>				
8. <i>Programs create inconsistent rules across the Agency and apply their own rules inconsistently.</i>	<i>More consistency in rule creation and application.</i>	<i>Rules are consistently applied.</i>	<i>Self adjusting business rules.</i>	

OM3 Prepare Remittance Advice/Encounter Report: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Utility or Value to Stakeholders</i>				
9. Business process complies with agency and state requirements	The agency benefits from introduction of automation	Agencies benefit from sharing of the business service and information with other agencies.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.	

OM4 Prepare Capitation Premium Payment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines</p>	<p><i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i></p> <p><i>Decisions take less time than level 1.</i></p>	<p><i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i></p> <p><i>Turnaround time can be immediate.</i></p>	<p><i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i></p>	<p><i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service.</i></p>
<i>Data Access and Accuracy</i>				
<p>2. At Level 1 the agency uses the claims payment process to produce capitation payments. The agency identifies members who have elected or have been auto-assigned to a managed care organization, a benefit manager, or a primary care physician, and matches them to appropriate rate cells, to calculate monthly payments. Adjustments are manually applied.</p>	<p><i>At Level 2, capitation payments are automatically produced and conform to HIPAA standards. Some transactions continue to be manually processed at the request of the other insurer.</i></p>	<p><i>The agency uses MITA standard interfaces for the capitation payments.</i></p>	<p><i>At Level 4, RHIOs orchestrate transfer of funds to MCO accounts and access clinical information to determine special payments. Payments are made directly to managed care bank accounts via RHIO registries.</i></p>	<p><i>Agency can make premium payments to any managed care organization or insuring organization at any location in the country via the NHIN.</i></p>
<p>3. Standards for the capitation payment transaction are agency-specific.</p>	<p><i>The agency implements HIPAA-compliant standards for electronic premium payments, however, the other insurance</i></p>	<p><i>The agency uses MITA standard interfaces which incorporate HIPAA premium payment schema for</i></p>		

OM4 Prepare Capitation Premium Payment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
	<i>companies impose their specific Implementation Guide requirements.</i>	<i>identification of managed care program enrollees, and preparation of the capitation premium payments.</i>		
4.			<i>Clinical information is accessed directly from the MCO/PCP if the capitation payment is supplemented for special circumstances, e.g., high risk pregnancy.</i>	
<i>Effort to Perform; Efficiency</i>				
5.	<i>Although data is electronic, much of the review and verification of information must be done manually.</i>	<i>The agency has the flexibility to easily change the criteria for rate cells.</i>	<i>Data triggers registry updates and pushes data to other applications (eg, EHRs, Immunization registries; and care/disease management applications)</i>	
<i>Cost-Effectiveness</i>				
6. <i>Large number of staff required to perform business process.</i>	<i>Less staff required to perform business process. Automation leads to fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care/disease management; stakeholder satisfaction</i>	
<i>Accuracy of Process Results</i>				
7. <i>Programs create inconsistent rules across the Agency and apply their</i>	<i>Business rules used to identify candidates are automated on a state-specific basis.</i>	<i>Rules are consistently applied.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	

OM4 Prepare Capitation Premium Payment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>own rules inconsistently.</i>	<i>More consistency in rule creation and application than level 1.</i>			
<i>Utility or Value to Stakeholders</i>				
8. Business process complies with agency and state requirements	<i>The agency benefits from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

OM4 Prepare Health Insurance Premium: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines</i></p>	<p><i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i></p> <p><i>Decisions take less time than level 1.</i></p>	<p><i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i></p> <p><i>Turnaround time can be immediate.</i></p>	<p><i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i></p>	<p><i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service.</i></p>
<i>Data Access and Accuracy</i>				
<p>2. <i>The agency identifies members who meet criteria for buy-in to other insurance coverage through primarily manual processes including a cost/benefit analysis of the individual case.</i></p>	<p><i>Some transactions continue to be manually processed at the request of the other insurer.</i></p>	<p><i>The agency uses MITA standard interfaces for identification of candidates for other payer buy-in, analysis of cost/ effectiveness, and health insurance premium payments.</i></p>	<p><i>Payments are made directly to other insurer bank accounts via RHIO registries.</i></p>	<p><i>Agency can make premium payments to any insurer at any location in the country via the NHIN.</i></p>
<p>3. <i>There are no standards for these transactions.</i></p>	<p><i>The agency implements HIPAA-compliant standards for electronic premium payments, however, the other insurance companies impose their specific Implementation Guide requirements.</i></p>	<p><i>Medicaid collaborates with other payers to use the national standards.</i></p>		
<p>4.</p>			<p><i>Access to clinical information helps to identify members</i></p>	

OM4 Prepare Health Insurance Premium: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
			<i>eligible for other insurance programs.</i>	
<i>Effort to Perform; Efficiency</i>				
<i>5. Verification is manual and if difficult then may require a longer amount of time.</i>	<i>Verification is mostly automated.</i>	<i>Verification is fully automated and immediate. Automated verification and application response are real time.</i>	<i>Internal and regional person/patient registries and other enrollment data sources can be auto/ad hoc queried for changes in verification or enrollment status;</i>	
<i>Cost-Effectiveness</i>				
<i>6. Large number of staff required to perform business process.</i>	<i>Less staff required to perform business process. Automation leads to fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction.</i>	
<i>Accuracy of Process Results</i>				
<i>7. The agency pays the premium according to the insurance company requirements.</i>	<i>Business rule to identify candidates and analyze cost/effectiveness are automated on a state-specific basis.</i>	<i>The agency has the flexibility to easily change the criteria for identification of members eligible for other insurance buy-in.</i>	<i>Self adjusting business rules.</i>	
<i>Utility or Value to Stakeholders</i>				
<i>8. Business process complies with agency and state requirements</i>	<i>The agency benefits from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease</i>	

OM4 Prepare Health Insurance Premium: Business Capabilities¹

<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Level 5</i>
			<i>management.</i>	

OM4 Prepare Medicare Premium Payment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.</i>	<i>Timeliness exceeds legal requirements.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.</i>
<i>Data Access and Accuracy</i>				
2. <i>The agency identifies members who meet criteria for buy-in to Medicare Part B. The agency prepares the Medicare Part B premium buy-in report.</i>		<i>The agency uses MITA standard interfaces for identification of candidates for Medicare Buy-in.</i>	<i>Business process interfaces with other processes via federated architectures.</i>	<i>Agency can verify status of buy-in candidate in other states and jurisdictions via the NHIN before generating the premium payment.</i>
3. <i>The agency exchanges information with the SSA using electronic communication standards specified by SSA. At Level 1, tape exchange is the primary medium.</i>		<i>The agency collaborates with other agencies to identify potential buy-ins.</i>		
4.	<i>CMS has not adopted the HIPAA standard for premium payment for this transaction so there is no national improvement available for this part of the process.</i>	<i>Medicaid agencies and CMS use a standard interface for the premium payment.</i>		

OM4 Prepare Medicare Premium Payment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Effort to Perform; Efficiency</i>				
5. <i>Updates are completed (keyed) manually.</i>	<i>Updates are automatically processed.</i>	<i>Updates are distributed to data sharing partners. Distributed update notifications to federated registries.</i>	<i>Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)</i>	<i>Any data exchange partner can send a notification regarding a record update to any other program in the USA.</i>
<i>Cost-Effectiveness</i>				
6. <i>Large number of staff required to perform business process.</i>	<i>Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.</i>	<i>Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.</i>
<i>Accuracy of Process Results</i>				
7. <i>Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and</i>	<i>Agencies use business rules to improve identification of buy-in candidates, prepare the premium payment calculation, and track the data exchange.</i>	<i>The agency has the flexibility to easily change the criteria for identification of buy-in candidates.</i>	<i>Self adjusting business rules.</i>	

OM4 Prepare Medicare Premium Payment: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>information quality and completeness.</i>				
<i>Utility or Value to Stakeholders</i>				
8. <i>Focus is on conducting business functions as efficiently as possible.</i>	<i>Automation and coordination processes enable staff to focus more on member and provider management.</i>	<i>Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.</i>	<i>Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.</i>

OM5 Inquire Payment Status: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.</i>	<i>Timeliness exceeds legal requirements.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i>	<i>Adjudication results are known immediately, eliminating the need for claim status inquiries. Provider systems collaborate with the MMIS during an episode of care. When the episode of care has concluded, the service is reimbursed or not and the provider knows the payment status immediately, eliminating the need for payment status inquiry.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.</i>
<i>Data Access and Accuracy</i>				
2. <i>The claim status inquiry process is primarily a manual process and is associated with a specific service. Providers inquire about the current adjudication status of a claim by phone, fax, or paper.</i>	<i>Programs employ AVR, legacy direct data entry, and point of service devices for electronic claim status responses.</i> <i>Staff may still manually handle inquiries that are not resolved with automated response.</i>	<i>All programs use a centralized automated electronic claim status process.</i>	<i>At Level 4, claims processing is replaced by direct communication between the provider's CLINICAL DATA system and the payer system.</i>	<i>At Level 5, inquiries can be launched and responded to nationally through the NHIN.</i>
3.		<i>Interfaces use MITA standards. Providers send HIPAA X12 276 or use online direct data entry and receive HIPAA X12 277 response or find the claim status online.</i>		
4. <i>Staff performs search on the claims history data store (for claims in process)</i>				

OM5 Inquire Payment Status: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>or the claims history repository for claims that have been adjudicated. Search may be based on the claim ICN, date of service, or patient name.</i>				
<i>Effort to Perform; Efficiency</i>				
<i>5. Updates are completed (keyed) manually.</i>	<i>Updates are automatically processed.</i>	<i>Updates are distributed to data sharing partners. Distributed update notifications to federated registries.</i>	<i>Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)</i>	<i>Any data exchange partner can send a notification regarding a record update to any other program in the USA.</i>
<i>Cost-Effectiveness</i>				
<i>6. Process is time-consuming for providers and resource intensive for agency.</i>	<i>The data uses agency standards and access is less time-consuming, less burdensome, and requires fewer agency resources.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.</i>	<i>Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.</i>
<i>Accuracy of Process Results</i>				
<i>7. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and</i>	<i>More consistency in decision making/rules / validation.</i>	<i>Consistency and predictability of the process.</i> <i>Rules are consistently applied. Decisions are uniform.</i>	<i>Use of clinical data improves consistency of results.</i>	<i>Use of clinical data improves consistency of results on a national scale.</i>

OM5 Inquire Payment Status: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and information quality and completeness.</i></p>				
<p><i>Utility or Value to Stakeholders</i></p>				
<p>8. <i>Focus is on conducting business functions as efficiently as possible.</i></p>	<p><i>Automation and coordination processes enable staff to focus more on member and provider management.</i></p>	<p><i>Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.</i></p>	<p><i>The providers' systems alert the provider to any clinical protocols and to any business rules required by the agency in order for the service to be paid.</i></p>	<p><i>Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.</i></p>

OM6 Calculate Spend-Down Amount: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.</i>	<i>Timeliness exceeds legal requirements.</i>	<i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.</i>
<i>Data Access and Accuracy</i>				
2. <i>The Calculate Spend-Down Amount business process is primarily paper based. An applicant's costs for health services are tracked by adding paper bills and receipts until the spend-down amount for each period is met.</i>	<i>The Calculate Spend-Down Amount business process is conducted electronically.</i>	<i>Instead, members are made eligible for Medicaid coverage with a deductible amount equal to their spend-down requirements for the specified period.</i>		N/A
3. <i>Applicants may be required to submit a paper spend-down report.</i>	<i>Applicants submit electronic spend-down reports, and either scan, fax, or mail health care bills and receipts.</i>	<i>The Calculate Spend-down Amount business process does not require that members report their costs.</i>	<i>Providers enter new service information into clinical records at various locations. If a client is flagged as a candidate.</i>	
4. <i>If spend-down is met, staff keys change in eligibility status into the applicant's record so that subsequent claims will pay for a specified period.</i>	<i>If spend-down is met, staff keys change in eligibility status into the applicant's record so that subsequent claims will pay for a specified period.</i>			
5.	<i>Although the X12 270-271 supports transmission of spend</i>	<i>Agencies support transmission of spend down information on</i>	<i>Business process interfaces with other processes via</i>	

OM6 Calculate Spend-Down Amount: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
	<i>down information, this purpose is not mandated by HIPAA.</i>	<i>the X12 270-271.</i>	<i>federated architectures.</i>	
<i>Effort to Perform; Efficiency</i>				
6. Updates are completed (keyed) manually.	<i>Updates are automatically processed.</i>	<i>The member's account accumulator automatically accounts for excess resources during claims processing by debiting the amount paid by the member. Once spend-down has been met, Medicaid payments to begin and/or resume. Spend down is essentially eliminated as a distinct business process.</i>	<i>Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)</i>	<i>Any data exchange partner can send a notification regarding a record update to any other program in the USA.</i>
<i>Cost-Effectiveness</i>				
7. Large number of staff required to perform business process.	<i>Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.</i>	<i>Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.</i>
<i>Accuracy of Process Results</i>				
8. Staff applies spend down rules to decide whether the submitted costs are	<i>Providers have difficulty determining whether the member has a spend down</i>	<i>Providers are able to determine the spend-down amount when they verify eligibility. Providers</i>	<i>Use of clinical data improves consistency of results.</i>	<i>Use of clinical data improves consistency of results on a national scale.</i>

OM6 Calculate Spend-Down Amount: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>allowable and in which period to apply the costs, sometimes resulting in inconsistent determinations or controversy with the applicant.</i></p>	<p><i>requirement and how much the member must still pay before the provider may bill Medicaid. As a result, providers unnecessarily submit claims that are denied because the member has not yet met spent down requirements and there is no member accounting accumulator for member payments toward meeting spend-down.</i></p>	<p><i>submit claims which are denied for billing to the member until spend down is met.</i></p>		
<p><i>Utility or Value to Stakeholders</i></p>				
<p><i>9. Focus is on conducting business functions as efficiently as possible.</i></p>	<p><i>Automation and coordination processes enable staff to focus more on member and provider management.</i></p>	<p><i>From the perspective of providers and members, other than billing the member, there is no difference between spend down and the processing of other Medicaid claims.</i></p>	<p><i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.</i></p>	<p><i>Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.</i></p>

OM6 Prepare Member Premium Invoice:: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>9. Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines</p>	<p><i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i></p> <p><i>Decisions take less time than level 1.</i></p>	<p><i>Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.</i></p> <p><i>Turnaround time can be immediate.</i></p>	<p><i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i></p>	<p><i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service.</i></p>
<p>10.</p>		<p><i>Payments can be accepted at all Agency sites. Payment can be in the form of cash, check, or credit or debt card.</i></p>		
<i>Data Access and Accuracy</i>				
<p>11. The agency uses manual procedures to maintain member accounting for premium invoicing and payment; maintain transaction history of all monies received or paid out of the member account; and reimburse members for HIP payments; support member contribution accumulators to determine out of pocket maximums or</p>	<p><i>Program specific accounting modules maintain a detailed transaction history of all monies received from members, such as pay-in or premiums, and monies paid out from a member's account to reimburse for HIPP payments.</i></p>	<p><i>Information from all program eligibility systems is used to establish the amount of the member liability in a centralized member accounting system associated with the Member Registry</i></p>		

OM6 Prepare Member Premium Invoice:: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>spend down requirements.</i>				
12. Member liability records are siloed by program and based on program specific eligibility records.	<i>Member account records are created when staff input amounts received from member pay-in or premium payment collection. Current balances and transaction history are stored for online viewing.</i>	<i>Member liability amounts are updated by MMIS with online adjustment capability. Member cost sharing accounts are maintained and updated by claims or member direct premium or pay in payments activity.</i>		
13.		<i>Details of the transaction are posted to the member accounting modules on the MMIS and then sent to the Agency financial systems.</i>		
<i>Effort to Perform; Efficiency</i>				
14. Invoicing and payment receipt are manual processes requiring data entry for payment	<i>Although data is electronic, much of the review and verification of information must be done manually.</i>	<i>The agency has the flexibility to easily change the criteria for rate cells.</i>	<i>Data triggers registry updates and pushes data to other applications (eg, EHRs, Immunization registries; and care/disease management</i>	

OM6 Prepare Member Premium Invoice:: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>processing and for the changes in member liability due to eligibility status.</i>			<i>applications)</i>	
15. Total payments are manually compared to the member's benefit package requirement for out of pocket expenses.		<i>Total payments are automatically compared to the member's benefit package requirement for out of pocket expenses.</i>		
<i>Cost-Effectiveness</i>				
16. Large number of staff required to perform business process.	<i>Less staff required to perform business process. Automation leads to fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data will refocus staff on performance outcomes; care/disease management; stakeholder satisfaction</i>	
<i>Accuracy of Process Results</i>				
17. Member accounting may be program specific, resulting in members receiving invoices and reimbursements from, and making premium payments to different parts of the Agency.	<i>Payments are subject to program specific rules.</i>	<i>The process creates a debit when payments are made; overpayments are credited to the account and refunds made to the member by check, EBT.</i>		

OM6 Prepare Member Premium Invoice:: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Utility or Value to Stakeholders</i>				
<p>18. Notices are manually generated and sent on paper to members advising them of their hearing rights and the amount of their contribution.</p>	<p>Notices are automatically generated by each program and sent on paper to members advising them of their hearing rights and the amount of their contribution.</p>	<p>Notices automatically are sent to the member from a central enterprise-wide member communications management business area advising them of their hearing rights and the amount of their client contribution. Notices are automatically sent to the member when annual maximums are met for any program.</p>		

OM7 Manage Drug Rebate: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Reporting, analysis, and responses to pharmaceutical companies and CMS inquiries are not timely and data may not be accurate.</i>	<i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than level 1.</i>	<i>Communications are more consistent, timely and appropriate.</i>	<i>Clinical data is available in real time.</i>	<i>Processes are further enhanced through connectivity with other states and federal agencies.</i>
<i>Data Access and Accuracy</i>				
2. <i>At this level, the Manage Drug Rebate business process is primarily paper invoice processing.</i>	<i>At this level, the Manage Drug Rebate business process uses electronic interchange and automated processes; for example, magnetic tape downloads and shared drives from legacy systems support state generation of rebate information.</i>	<i>At this level, the Manage Drug Rebate business process uses MITA standard interfaces.</i>	<i>Drug rebate is replaced by a new strategy where care management and disease management interact with provider EHRs.</i>	<i>Data exchange is on a national scale. Through peer-to-peer collaboration, real-time access to source data ensures accuracy, eliminates redundant collection and interchange of data, and improves process performance.</i>
3. <i>Programs are siloed so rebate process may be uncoordinated, e.g., mental health, waiver, and shared programs with health departments such as ADAP, pay for drugs but may not participate in the state drug rebate program.</i>	<i>Agencies are centralizing drug utilization data from siloed programs as inputs to the drug rebate process to achieve economies of scale, increase coordination, improve rule application consistency, and standardize data to increase rebates.</i>	<i>The Agency supports data and technology integration and interoperability.</i>		
4. <i>Non-standardized data and</i>	<i>Data is mostly standardized.</i>	<i>Data is standardized for</i>		

OM7 Manage Drug Rebate: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>format makes any type of cross program management reporting and analysis for drug rebate purposes is difficult and costly.</i>		<i>automated electronic interchanges (interfaces) between agencies and drug manufacturers.</i>		
5. <i>Access to data is limited by legacy systems and CMS reporting cycles.</i>				
<i>Effort to Perform; Efficiency</i>				
6. <i>Rebate information is manually validated.</i>	<i>Validation is mostly automated.</i>	<i>Validation is fully automated.</i>		
<i>Cost-Effectiveness</i>				
7. <i>Cost-effectiveness is impacted by lack of data accuracy and completeness (missing data from siloed programs), manual processing, and need for CMS quarterly reporting of rebate information.</i>	<i>Increased data accuracy and completeness creates more cost-effectiveness.</i>	<i>Agencies adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally all of which improve cost-effectiveness.</i>	<i>Agency transforms operations from labor intensive to strategic planning.</i>	
<i>Accuracy of Process Results</i>				
8. <i>Programs create inconsistent rules across the Agency and apply their own rules inconsistently.</i>	<i>More consistency in rule creation and application.</i>	<i>Rules are consistently applied.</i>	<i>Self adjusting business rules.</i>	
<i>Utility or Value to Stakeholders</i>				
9. <i>Cost-effectiveness is</i>	<i>Cost management programs</i>	<i>Focus is on Member, Provider,</i>	<i>Providers, members, and care</i>	

OM7 Manage Drug Rebate: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>impacted by lack of data accuracy and completeness (missing data from siloed programs), manual processing, and need for CMS quarterly reporting of rebate information. These may factor into the Medicaid drug formulary and clinical protocol decisions, which affects many stakeholders.</i></p>	<p><i>are implemented that bring value to stakeholders.</i></p>	<p><i>and Medicaid Operations business services. Stakeholders will experience increased satisfaction in the way their needs are met.</i></p>	<p><i>managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i></p>	

OM7 Manage Estate Recovery: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>Generating correspondence, e.g., demand of notice to probate court to member's personal representatives and notices of intent to file claim, is not timely.</i></p>	<p><i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i></p> <p><i>Decisions take less time than level 1.</i></p>	<p><i>Communications to stakeholders and member's personal representatives are consistent, timely, and appropriate.</i></p>	<p><i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i></p>	<p><i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service. Optimal resources, timeliness, and disposition consistency.</i></p>
<i>Data Access and Accuracy</i>				
<p>2. <i>At this level the Manage Estate Recovery business process is primarily a mix of paper, phone, fax and proprietary EDI.</i></p>	<p><i>At this level, the Manage Estate Recovery business process uses electronic interchange and automated processes, for example, receiving data from Community Service Offices, date of death matches, probate petition notices and reports of death from nursing homes which increases coordination and improves timeliness, consistency, and access for stakeholders involved in the process.</i></p>	<p><i>At this level, the Manage Estate Recovery business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. MITA standard interfaces are used for electronic interchanges (interfaces) between agencies.</i></p>	<p><i>The data exchange necessary for estate recovery is accessed via regional registries for member and third party resources</i></p>	<p><i>Data exchange is on a national scale. Through peer-to-peer collaboration between the agency and provider EHRs or other program applications, e.g., health departments for date of death matches, real-time access to source data ensures accuracy, eliminates redundant collection and interchange of data and improves process performance.</i></p>
<p>3. <i>Non-standardized data and format from multiple sources requires manual compilation of data.</i></p>	<p><i>Agencies are standardizing data to increase coordination and consistency, therefore enhancing usefulness for</i></p>	<p><i>HIPAA compliant standards / national standards drive data and format of process.</i></p>		

OM7 Manage Estate Recovery: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
	<i>determining the value of estate liens and improving the timeliness and accuracy of the case follow-up, ensuring recovery is completed and Member registry and payment history are updated.</i>			
<i>4. Access to data is limited by the sporadic, inconsistent, and untimely receipt of data and updates to member eligibility.</i>				
<i>Effort to Perform; Efficiency</i>				
<i>5. Information is manually validated.</i>	<i>Validation is mostly automated.</i>	<i>Validation is fully automated.</i>	<i>The data exchange necessary for estate recovery is accessed via regional registries for member and third party resources</i>	
<i>Cost-Effectiveness</i>				
<i>6. Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing.</i>	<i>Increased data accuracy and completeness creates more cost-effectiveness.</i>	<i>Agencies adopt national standards, develop shared business services, collaborate on common programs, and exchange information intra-state and regionally all of which improve cost-effectiveness.</i>		
<i>Accuracy of Process Results</i>				
<i>7. Cost effectiveness is impacted by lack of data</i>	<i>Increased data accuracy and completeness creates more</i>	<i>Rules are consistently applied. Decisions are uniform.</i>	<i>Use of clinical data improves consistency of results.</i>	

OM7 Manage Estate Recovery: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<p><i>accuracy and completeness, and manual processing. This adversely affects the accuracy and amount of recovery which could in turn affect many stakeholders.</i></p>	<p><i>cost-effectiveness.</i></p>			
<p><i>Utility or Value to Stakeholders</i></p>				
<p><i>8. Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing. This adversely affects the accuracy and amount of recovery which could in turn affect many stakeholders.</i></p>	<p><i>Cost management programs are implemented that bring value to stakeholders.</i></p>	<p><i>Focus is on Member, Provider, and Medicaid Operations business services. Stakeholders will experience increased satisfaction in the way their needs are met.</i></p>	<p><i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i></p>	

OM7 Manage Recoupment: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. <i>Decisions may take several days.</i>	<i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i> <i>Decisions take less time than level 1.</i>	<i>Communications to providers are consistent, timely and appropriate.</i>	<i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i>	<i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service. Optimal resources, timeliness, and disposition consistency.</i>
<i>Data Access and Accuracy</i>				
2. <i>At this level, the Manage Recoupments process is likely primarily a manual process.</i>	<i>At this level, the Manage Recoupments process is increasing its use of electronic interchange and automated processes.</i>	<i>At this level, the Manage Recoupments business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.</i>	<i>At this level, the Manage Recoupments business process interfaces with other processes via federated architectures, e.g., from Medicaid agency to an outside entity or payer.</i>	<i>At this level, Manage Recoupments business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing</i>
3. <i>Communications to providers and other payers are accomplished via phone and mail.</i>	<i>Communication via Web portals, email, dial-up, POS, and EDI.</i>	<i>There is more application-to-application communications e.g., applying refund in the system and updating payment history which results in less manual intervention resulting in less maintenance and time savings.</i>		
4. <i>Format is not HIPAA compliant, recouping of</i>	<i>Some agencies are sending electronic 837s directly to other</i>	<i>Communications via MITA standard interfaces.</i>		

OM7 Manage Recoupment: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>monies in third party liability situations is accomplished from payer to provider rather than payer to payer.</i>	<i>payers rather than from payer to provider.</i>			
5. Non-standardized data makes any type of cross program performance monitoring, management reporting, fraud detection, or reporting and analysis difficult and costly.	<i>More of the formatting is HIPAA compliant resulting in standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.</i>			
<i>Effort to Perform; Efficiency</i>				
6. Validation is manual.	<i>Most validation is automated.</i>	<i>Validation is fully automated and immediate.</i>	<i>Data triggers registry updates and pushes data to other applications</i>	
<i>Cost-Effectiveness</i>				
7. Maintenance continues to be expensive and time-consuming.	<i>Less staff required to perform business process. Automation leads to fewer staff.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.</i>	
<i>Accuracy of Process Results</i>				
8. Inconsistency in rule	<i>There is an increase in</i>	<i>Consistency and predictability</i>	<i>Use of clinical data improves</i>	

OM7 Manage Recoupment: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>application.</i>	<i>coordination between the provider utilization role, recoupments and accounting resulting in rule application consistency.</i>	<i>of the process.</i> <i>Rules are consistently applied. Decisions are uniform.</i>	<i>consistency of results.</i>	
<i>Utility or Value to Stakeholders</i>				
9. <i>Business process complies with agency and state requirements</i>	<i>The agency benefit from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

OM7 Manage Settlement: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>Decisions may take several days.</i></p>	<p><i>Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.</i></p> <p><i>Decisions take less time than level 1.</i></p>	<p><i>Process can be immediate.</i></p>	<p><i>Process time is immediate. Clinical data is available in real time. Processes that use clinical data result in immediate action, response, and outcomes.</i></p>	<p><i>Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Most business processes are executed at the point of service. Optimal resources, timeliness, and disposition consistency.</i></p>
<i>Data Access and Accuracy</i>				
<p>2. <i>At this level, the Manage Settlements business process is likely primarily paper based processing and some proprietary EDI.</i></p>	<p><i>At this level, the Manage Settlements business process is increasing its use of electronic interchange and automated processes.</i></p>	<p><i>At this level, the Manage Settlements business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.</i></p>	<p><i>At this level, the Manage Settlements business process interfaces with other processes via federated architectures.</i></p>	<p><i>At this level, the Manage Settlements business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.</i></p>
<p>3. <i>Non-standardized data makes any type of reporting and analysis difficult and costly.</i></p>	<p><i>Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting and analysis.</i></p>	<p><i>Data is standardized for automated electronic interchanges (interfaces).</i></p>		
<i>Effort to Perform; Efficiency</i>				

OM7 Manage Settlement: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
4. <i>Information is manually validated.</i>	<i>Validation is mostly automated.</i>	<i>Validation is fully automated.</i>	<i>Data triggers registry updates and pushes data to other applications</i>	
<i>Cost-Effectiveness</i>				
5. <i>Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing.</i>	<i>Increased data accuracy and completeness creates more cost-effectiveness.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.</i>	
<i>Accuracy of Process Results</i>				
6. <i>Programs create inconsistent rules across the Agency and Agencies apply their own rules inconsistently.</i>	<i>More consistency in program rule application.</i>	<i>Rules are consistently applied.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	
<i>Utility or Value to Stakeholders</i>				
7. <i>Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing. This adversely affects the accuracy and amount of recovery which could in turn affect many stakeholders.</i>	<i>Cost management programs are implemented that bring value to stakeholders.</i>	<i>Focus is on Member, Provider, and Medicaid Operations business services. Stakeholders will experience increased satisfaction in the way their needs are met.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

OM7 Manage TPL Recovery: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
1. Reporting and responses from third party payers are not timely and data may not be accurate.	Communications more consistent, timely, and appropriate than level 1.	Communications consistent, timely, and appropriate.	Response and payment outcomes are immediate.	Processes are further enhanced through connectivity with other states and federal agencies.
<i>Data Access and Accuracy</i>				
2. The Manage TPL Recoveries process is primarily a mix of paper, phone, fax and proprietary EDI.	The Manage TPL Recoveries process uses agency specified electronic interchange and automated processes. Electronic or magnetic tape downloads from other agencies are used for data matches support access to member eligibility data.	The Manage TPL Recoveries business process uses MITA standard interfaces for payer-to payer COB process reducing the burden to providers and optimizing timeliness.	COB is automatically coordinated through the local RHIO registry.	Data exchange for COB occurs on a national scale. Through peer-to-peer collaboration, member and provider data is accessible through RHIO relays across the country.
3. Programs are siloed so the recovery process may be uncoordinated.				
4. TPL recovery is accomplished primarily via payer-to-provider COB.			Regional stakeholders are interoperable and payment determinations or denials are entirely a payer-to-payer process making the data immediate, accurate and consistent.	
5. Non-standardized data and format makes any type of	Mostly standardized data and format.	Data is standardized for automated electronic		

OM7 Manage TPL Recovery: Business Capabilities

Level 1	Level 2	Level 3	Level 4	Level 5
<i>cross program management reporting, and analysis difficult and costly.</i>		<i>interchanges (interfaces) between agencies and other payers.</i>		
<i>6. Access to data is limited by inter-agency and other payer legacy systems, i.e., capability related to data matches.</i>				
<i>Effort to Perform; Efficiency</i>				
<i>7. Information regarding third-party resources is manually validated.</i>	<i>Validation is automated.</i>	<i>Business services standardize requests and responses nationally.</i>	<i>Data triggers registry updates and pushes data to other applications</i>	
<i>Cost-Effectiveness</i>				
<i>8. Cost-effectiveness is impacted by lack of data accuracy and completeness, as well as inconsistency in how the rules and/or policies are applied to TPL recoveries, manual processing and timeliness.</i>	<i>Automation increases accuracy and cost-effectiveness.</i>	<i>Further reduction of staff required to perform business process.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care/disease management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.</i>	
<i>Accuracy of Process Results</i>				
<i>9. Inconsistency in the rules applied to TPL recoveries vary from agency to</i>	<i>More consistency in rule application.</i>	<i>Rules are consistently applied.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	<i>Real-time access to source data ensures accuracy, eliminates redundant collection and</i>

OM7 Manage TPL Recovery: Business Capabilities

OM7 Manage TPL Recovery: Business Capabilities				
Level 1	Level 2	Level 3	Level 4	Level 5
<i>agency.</i>				<i>interchange of data, and improves process performance.</i>
<i>Utility or Value to Stakeholders</i>				
<i>10. Business process complies with agency and state requirements</i>	<i>The agency benefit from introduction of automation</i>	<i>Agencies benefit from sharing of the business service and information with other agencies.</i>	<i>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care/disease management.</i>	

Program Integrity Management

PI Identify Candidate Case: Business Capabilities

Identify Candidate Case				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
23. Decisions may take several days . Timelapse of process is within agency, state and federal guidelines .	Timeliness exceeds legal requirements .	Process time can be immediate . Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	Process time is immediate . Clinical data is available in real time . Processes that use clinical data result in immediate action , response, and outcomes.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.
Data Access and Accuracy				
24. Mix of manual and automated processes .	Introduction of automated rules .	Standardized queries; automated alerts . Process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	Business process interfaces with other processes via federated architectures , including direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
25. Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI .	Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI . Automation increases accuracy of data.	Data is accessed / transferred / received via universally standard interfaces . Member-centric/"no wrong door".		
26. There is no single standard	Records for different programs	Records are stored in either a single Registry (eg, Provider or Member Registry) or federated Registries that can be accessed	Medicaid Registries are federated with regional data	Medicaid Registries are federated with regional data

PI Identify Candidate Case: Business Capabilities

Identify Candidate Case				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>for data stored for different types of data (eg, types of providers)</p> <p>27. Staff researches, maintains, and responds to information requests manually.</p> <p>28. Customers have difficulty accessing consistent, quality, or complete information (e.g., about about programs or services).</p> <p>29. Program areas require different rules / criteria and access points for</p>	<p>continue to be stored separately but can be accessed and aggregated as needed.</p> <p>Responses to requests for information are automated.</p> <p>Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.</p> <p>Rules/criteria and access points for similar business functions are the same across program areas</p>	<p>by all users of the data.</p> <p>Collaboration w/sister agencies (one-stop shop).</p> <p>Standard interfaces are used for inquiry and response for acquisition of information. One stop shop with inquiry and response.</p> <p>Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.</p> <p>Standardized application processes. Communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, stakeholder will be able to access information</p>	<p>exchange networks. Information, including clinical, can be shared among authorized entities within the RHIO.</p> <p>Some inquiries/responses are replaced by automated messages.</p> <p>In addition to Level 3 gains, certain messages are triggered by individual entries into</p>	<p>exchange networks across the country and if desired, internationally.</p> <p>Some inquiries/responses are replaced by automated messages, but on a national level.</p> <p>Stakeholder communications posted by an agency can be accessed anywhere in the</p>

PI Identify Candidate Case: Business Capabilities

Identify Candidate Case				
Level 1	Level 2	Level 3	Level 4	Level 5
similar business functions.		regardless of program.	electronic health records for prospective and current members. Access to online PHR or Web portal is available to support business functions.	country.
Effort to Perform; Efficiency				
30. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)	Any data exchange partner can send a notification regarding a record update to any other program in the USA.
Cost-Effectiveness				
31. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.	Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.
Accuracy of Process Results				
32. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create	More consistency in decision making/rules / validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Use of clinical data improves consistency of results.	Use of clinical data improves consistency of results on a national scale.

PI Identify Candidate Case: Business Capabilities

Identify Candidate Case				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and information quality and completeness.</p>				
Utility or Value to Stakeholders				
<p>33. Focus is on conducting business functions as efficiently as possible.</p>	<p>Automation and coordination processes enable staff to focus more on member and provider management.</p>	<p>Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.</p>	<p>Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.</p>	<p>Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.</p>

PI Manage Case: Business Capabilities

Manage Case				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
34. Decisions may take several days . Timelapse of process is within agency, state and federal guidelines .	Timeliness exceeds legal requirements .	Process time can be immediate . Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	Process time is immediate . Clinical data is available in real time . Processes that use clinical data result in immediate action , response, and outcomes.	Process time is immediate on a national scale via interoperable connectivity with other State and Federal agencies. Optimal resources, timeliness, and disposition consistency.
Data Access and Accuracy				
35. Mix of manual and automated processes .	Introduction of automated rules .	Standardized queries; automated alerts . Process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible.	Business process interfaces with other processes via federated architectures , including direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
36. Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI .	Data is accessed / transferred / received via Web portals, email, dial-up, POS, and EDI . Automation increases accuracy of data.	Data is accessed / transferred / received via universally standard interfaces . Member-centric/"no wrong door".		
37. There is no single standard for data stored for different types of data (eg, types of providers)	Records for different programs continue to be stored separately but can be accessed and aggregated as needed .	Records are stored in either a single Registry (eg, Provider or Member Registry) or federated Registries that can be accessed by all users of the data. Collaboration w/sister agencies (one-stop shop).	Medicaid Registries are federated with regional data exchange networks. Information, including clinical , can be shared among authorized entities within the	Medicaid Registries are federated with regional data exchange networks across the country and if desired, internationally .

PI Manage Case: Business Capabilities

Manage Case				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>38. Staff researches, maintains, and responds to information requests manually.</p> <p>39. Customers have difficulty accessing consistent, quality, or complete information (e.g., about about programs or services).</p> <p>40. Program areas require different rules / criteria and access points for similar business functions.</p>	<p>Responses to requests for information are automated.</p> <p>Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.</p> <p>Rules/criteria and access points for similar business functions are the same across program areas</p>	<p>Standard interfaces are used for inquiry and response for acquisition of information. One stop shop with inquiry and response.</p> <p>Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.</p> <p>Standardized application processes. Communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, stakeholder will be able to access information regardless of program.</p>	<p>RHIO.</p> <p>Some inquiries/responses are replaced by automated messages.</p> <p>In addition to Level 3 gains, certain messages are triggered by individual entries into electronic health records for prospective and current members. Access to online PHR or Web portal is available to support business functions.</p>	<p>Some inquiries/responses are replaced by automated messages, but on a national level.</p> <p>Stakeholder communications posted by an agency can be accessed anywhere in the country.</p>

PI Manage Case: Business Capabilities

Manage Case				
Level 1	Level 2	Level 3	Level 4	Level 5
Effort to Perform; Efficiency				
41. Updates are completed (keyed) manually.	Updates are automatically processed.	Updates are distributed to data sharing partners. Distributed update notifications to federated registries.	Data triggers registry updates and pushes data to other applications (eg, EHRs, registries)	Any data exchange partner can send a notification regarding a record update to any other program in the USA.
Cost-Effectiveness				
42. Large number of staff required to perform business process.	Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	Further reduction of staff required to perform business process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of staff focused on performance outcomes; care management; stakeholder satisfaction. Agency transforms operations from labor intensive to strategic planning.	Staff focused on performance outcomes; care management; stakeholder satisfaction on a national level. Maximized efficiency and cost effectiveness.
Accuracy of Process Results				
43. Inconsistent decision making/validation. Staff makes decisions autonomously and without consultation with other programs. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. Data issues with duplication, discrepancies between data stores, and information quality and	More consistency in decision making/rules / validation.	Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	Use of clinical data improves consistency of results.	Use of clinical data improves consistency of results on a national scale.

PI Manage Case: Business Capabilities

Manage Case				
Level 1	Level 2	Level 3	Level 4	Level 5
completeness.				
Utility or Value to Stakeholders				
44. Focus is on conducting business functions as efficiently as possible.	Automation and coordination processes enable staff to focus more on member and provider management.	Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.	Providers, members, and care managers access standardized Member Registries to view clinical data needed for EHRs, PHRs, and care management.	Additionally, the ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.

Program Management

Designate Approved Services and Drug Formulary: Business Capabilities

Designate Approved Services and Drug Formulary				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	The process is primarily manual; some analysis may be automated.	Data analysis is primarily automated.	Data analysis is automated and specialized applications are used to study patterns and “what if” analysis.	
What standards are used by this process?	There is a blend of national codes and special State-specific local codes.	The State adopts national codes under HIPAA legislation, but continues to translate significant numbers of these codes to non-standard State codes.	State adopts MITA standard interface and all standard codes (without translation).	
Is collaboration with other agencies or entities used in this process?	All agencies function independently. Each has its own codes and formulary.	Agencies agree to accept HIPAA standard codes, but each translates to its own requirements.	All agencies agree to use MITA specified interface standard including data standards.	
How adaptable to change is this process?	All changes are manually implemented. Changes must be scheduled as an IT	Most national codes are updated via an external service that maintains	Due to the ability of business experts to review and change	

Designate Approved Services and Drug Formulary				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	project.	currency of the codes. Internal changes are managed via version control. All changes are date-stamped.	parameters interactively, changes are quickly accommodated without the need for programming modifications.	
How does the agency make decisions regarding service and drug formulary?	Decisions are primarily based on fiscal impact and regulatory requirements rather than research into clinical data.	Improvements in data collection and analytical tools introduce the ability to make clinical criteria part of the decision making process.	Standardization of data and information exchange across agencies improves decision making.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	Meets agency goals for designating approved service codes.	By adhering to national standard codes, timeliness improves over Level 1.	Use of MITA approved code standards improves timeliness of agency approvals over Level 2.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manually processing the blend of national and state-specific local codes reduces accuracy of data.	Improved utilization of automation and the increased use of national standard codes results in greater accuracy than at Level 1.	Medicaid enterprise fully adopts MITA and national standard codes. Accuracy measured at 99% or better.	
How accessible is the information used in this process?	Information is relatively accessible.	Information is usually accessible and access to national data services is instantaneous.	Access to information is immediate.	
Business Capability Quality: Cost-Effectiveness				

Designate Approved Services and Drug Formulary				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
What is the ratio of the cost to perform this process compared to the benefits of the results?	Meets state guidelines for maintaining codes.	Effectiveness is improved because staff have better analytical tools to use in assessing code sets and formularies.	Effectiveness further improves through use of MITA standard interfaces and full adoption of HIPAA codes which can be compared across States.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The review and approval process is formalized and documented.	The review and approval process is more efficient than at Level 1 due to the use of automated tools.	Use of MITA standard interface (which includes data standards) improves efficiency over Level 2.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	There is a manual process for changes in services and formulary. Accuracy may be adversely affected.	Automated processes produce increased accuracy from Level 1.	Increased use of national codes and automated reviewing tools increases accuracy from Level 2.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholders desire improvements in timeliness and consistency of decisions.	Increased use of national standard codes improves stakeholder satisfaction over Level 1 with timeliness and consistency of decisions.	Use of MITA data standards further increases satisfaction over Level 2.	

Develop Agency Goals and Objectives: Business Capabilities

Develop Agency Goals and Objectives				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	This is a totally manual process.	At this level, some automation and tools are used to gather, record, analyze, formulate, communicate, and distribute information on goals and objectives to agency leadership and other state agencies.	Use of MITA standard definitions facilitates 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.	.
Does this process use standards?	There is an approach established by each agency that is State specific.	The agency has implemented the use of a methodology to support development of goals and objectives.	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	

Develop Agency Goals and Objectives				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
			used.	
Is collaboration with other agencies or entities used by this process?	The agency reacts primarily to external forces that indicate the need for change. Goals and processes to effect such change are internal in nature and may not include coordination with other agencies to develop goals and objectives.	The Medicaid agency gathers information from all leadership in the Medicaid enterprise. Other state agencies with obvious connections to Medicaid are asked to assist in the development of Medicaid's goals and objectives.	The goals and objectives are shared with and developed by all agencies that interface or are affected by the Medicaid enterprise. Other agencies assist in the collaborative development of the Medicaid agency's goals and objectives. Collaboration is wide spread among all parties who accept the MITA standard interfaces.	
How adaptable is this process to change?	This process follows established guidelines that are difficult to modify.	The agency is no longer a silo within the state. The agency goals and objectives are developed with newly implemented methodologies and collaboration from other agencies.	This process is fully adaptable to change and includes the use of methodologies to track the progress of the agency's goals and objectives.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The goals and objectives are developed in an ad hoc manner.	Implementation of standard methodologies leads to the	The agency is using standard methodologies that provide	

Develop Agency Goals and Objectives				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	<p>This may be triggered by a change in Administration or in receipt of revenue. This primarily manual process can take a significant amount of time.</p> <p>When an authority decides to redefine goals and objectives, the agency “re-invents the wheel” each time to accomplish the task. Time is indeterminate.</p>	<p>more frequent review and modification of the goals and objectives. This also imposes traceability throughout the organization to ensure that the activities of the organization match the goals and objectives.</p> <p>The task can be completed in less than one month.</p>	<p>traceability of the goals and objectives. The goals and objectives are now an integral part of the agency’s operations.</p> <p>The agency can develop, modify, track, and report on the goals and objectives in generally less than one week.</p>	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The agency is a silo and does not gather information from other agencies. Goals and objectives are vague and incomplete. Information gathered can be inaccurate, incomplete, or does not apply.	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 agencies.	Goals and objectives can be measured and are more accurate, applicable, and traceable than at Level 2.	
How accessible is the information used in this process?	The goals and objectives are vague and incomplete. The information needed is not readily available, located in many places, out-of-date, and difficult to verify.	Standard methodologies implemented have defined the sources for the information needed to develop and maintain goals and objectives. The information gathering has boundaries to ensure it is up-to-date and more accurate.	The information needed for goals and objectives development and maintenance is readily available, centrally located, up-to-date and easy to verify.	
Business Capability Quality: Cost Effectiveness				

Develop Agency Goals and Objectives				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
What is the ratio of the cost to perform this process compared to the benefits of the results?	Cost measurement is difficult due to the general and vague nature of the goals and objectives and the ad hoc nature of the process.	Standardization reduces the cost of development of goals and objectives as the quality increases.	The goals and objectives are cost effective and the results are accurate, dependable, traceable, and easy to maintain.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Measurement of efficiency is difficult due to the general and vague nature of the goals and objectives and the infrequent nature of the process.	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.	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.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The general and vague nature of the goals and objectives results in inaccurate and unrelated goals and objectives that satisfy a "task request" instead of milestones to achieve.	Standardized methodologies produce goals and objectives that are easily traceable throughout the organization.	The goals and objectives are connected to every part of the Medicaid enterprise and other state agencies.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	The general and vague nature of goals and objectives are not useful to stakeholders.	Standardization has provided clear and more useful information for stakeholders increasing satisfaction over Level 1.	Stakeholders collaborate in development of the goals and objectives for the Medicaid enterprise, further increasing	

Develop Agency Goals and Objectives

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
			stakeholder satisfaction over Level 2.	

Develop and Maintain Benefit Package: Business Capabilities

Develop and Maintain Benefit Package				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	This process is primarily manual.	The agency uses tools to extensively analyze data to support maintenance of the benefit packages.	MITA standardized data improves analysis and research required for maintenance of multiple benefit packages.	
What standards are used by this process?	The benefit plan is a document (there are no data standards).	Data standards are used to define benefit package components.	MITA approved data standards are used.	
Is collaboration with other agencies or entities used in this process?	There is no direct collaboration.	Medicaid collaborates with Waiver programs, other agencies, Managed Care Organizations (MCOs) through a Memorandum of Understanding (MOU) to define shared services.	Through collaboration the development and maintenance of benefit packages results in a comprehensive view for all stakeholders of the benefit packages.	
How adaptable to change is this process?	As a paper-based process, changes are difficult to accommodate.	There is more flexibility to adjust to change.	Maximum flexibility to make changes to benefit package based on agency decisions.	
How flexible are the contents of the benefit package?	Benefit package selections have pre-set services and provider types.	Waiver programs are structured to permit more flexibility around	All programs introduce flexibility within benefit packages, enabling	

Develop and Maintain Benefit Package				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
		selection of services and providers within a benefit package.	consumer driven health care with more choices among services and provider types.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The benefit package changes take a significant amount of time to complete, depending on the complexity and cost of coverage affected.	Automation of analysis facilitates prompt maintenance of the benefit package.	Use of MITA standard data further improves timeliness of updates to the benefit plan.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The manual nature of this process introduces the potential for inaccuracies.	More automation and standardization reduces inaccuracies.	Use of MITA standard interfaces further reduces inaccuracies.	
How accessible is the information used in this process?	The benefit package details are not published or widely distributed.	The benefit packages are published on State's web site.	Benefit package information is available to the general public.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Benefit package maintenance is duplicated among multiple agencies including the Medicaid agency. Lack of coordination reduces effectiveness.	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.	Use of MITA standard interface and incorporation of one-stop-shop into the design, result in maximum cost/effectiveness.	
Business Capability Quality: Effort to Perform; Efficiency				

Develop and Maintain Benefit Package				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
How efficient is this process?	Changes to the benefit plan are primarily manual creating inefficiency.	Automation improves efficiency.	The benefit packages are easily modified through a user interface and are immediately available to claims processing.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How useful or accurate are the results of this process?	Benefit packages are inflexible and lock members into a single package.	Benefit packages are somewhat flexible but cannot be shared across programs.	Benefit packages are very flexible and can be shared across programs.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	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.	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.	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 based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	

Develop and Manage Performance Measures Reporting: Business Capabilities

Develop and Manage Performance Measures Reporting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
<p>Business Capability Descriptions</p> <p>This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.</p>				
How manual or automated is this business process?	The process is manual and duplicated in multiple areas within the organization.	The process is a mix of manual and automated processes to gather data and perform calculated outcomes measures.	The process is fully automated with few exceptions.	
Does this process use standards?	Standardized measures developed by the federal or state governments have been applied to a few Medicaid processes and programs. There may be inconsistencies among agency divisions.	Standardized industry performance measures in addition to federal or state performance measures have been applied to many of the Medicaid enterprise processes and programs.	The process uses MITA standardized interfaces and data definitions to standardize performance measures for all Medicaid enterprises and programs.	
How are data used in this process verified?	Data is manually verified prior to release.	Data verification prior to release is a mix of manual and automated processes.	Data verification is fully automated.	
Are performance measures published?	Measures are produced manually and distributed to other parties	Measurements are electronically published.	Based on use of MITA standard interfaces and data definitions States	

Develop and Manage Performance Measures Reporting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	responsible for the activity.		may share outcome measures with other States and federal agencies..	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	This process occurs periodically (weekly, monthly, quarterly, and annually) to meet state and federal timeliness requirements.	Automated receipt of data insures a more timely availability of information than found at level 1.	Information can be refreshed daily on dashboard. Periodicity of posting is up to the state.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	There are some issues regarding data accuracy and completeness and some calculation errors occur.	Internal standardization of data, use of HIPAA data exchange standards, and increased use of automation reduces inaccuracies in data.	Use of standard MITA interface further reduces data errors.	
How accessible is the information used in this process?	Access to data to perform measurement is primarily a manual process. Communication is limited to paper, email, Compact Disc (CD) or publications.	Access to data to perform measurement is primarily through an automated process. Communication occurs through email, Compact Disc (CD) or publication on State's website.	Performance measurement is built into individual business processes and also consolidated into state-level dashboards. Access to data using MITA standard interface which increases accessibility.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	The business process is manual and may take several weeks to gather specified data for	The business process is mix of automated and manual processes with reduced cost to produce	Use of MITA standard interfaces and inclusion of performance measures in individual	

Develop and Manage Performance Measures Reporting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	calculation. Accuracy of calculations is manually verified. Publication of outcomes measurement is valuable to State in monitoring efforts.	data and increased value to the State as result of publication of outcomes to public. Automation improves effectiveness of performance measures.	business processes increases cost-effectiveness of this process.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processing, lack of coordination with other processes, duplicative work may result in many opportunities to create or improve efficiency.	Increased automation, coordination with other processes, and introduction of standards reduce duplicative work and create more efficiency.	Use of MITA standards increases efficiency of this process.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Manual review and verification of accuracy of calculations is needed prior to publication. Manual processes may be error prone.	Less manual review and verification of accuracy of calculations is needed prior to publication due to automation resulting in improved accuracy of the results.	Accuracy increases over level 2 due to the use of MITA standard interfaces.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is negatively impacted by manual processes, with few resources dedicated to	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations	Medicaid enterprise conducts internal and external audits/focus groups which take into	

Develop and Manage Performance Measures Reporting

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	<p>improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.</p>	<p>and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.</p>	<p>consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.</p>	

Formulate Budget: Business Capabilities

Formulate Budget				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	The process is a mix of manual and automated processes to gather financial data. State-specific applications are used for expenditure forecasting calculations, budget models, and forecasting projections.	This is an automated process supported by Commercial off the shelf (COTS) predictive modeling and expenditure forecasting tools that may be implemented in the decision support system (DSS).	State has implemented use of automated COTS forecasting packages that comply with MITA standard interfaces.	
What standards are used by this process?	The process meets all state and federal requirements for budget development. There are no specific standards.	Medicaid enterprise has selected COTS tools that impose internal standards.	MITA standard interfaces are used in the budget development process.	
Is collaboration with other agencies or entities used by this process?	Collaboration is limited to a manual effort to gather information from other entities that have input to the budget.	Medicaid enterprise utilizes some collaboration with stakeholders and other agencies to develop an enterprise-wide budget.	Collaboration improves as other agencies and entities adopt MITA standard interface for updating the budget.	
Are data and format standardized?	Data is entered in standard formats from	The process is supported by standard financial	Process uses the MITA standard interface.	

Formulate Budget				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	multiple sources.	COTS offering more automation and standardization than Level 1. Data maintained in the data warehouse is accessed with DSS tools meets local standards.		
How are data used in this process verified?	The process is primarily a manual effort to gather and verify financial information and cost projections.	The process is a mixture of automation and manual intervention to gather and verify financial information and cost projections.	Adherence to MITA standard interface specifications ensures accuracy of data.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	This business process is required to meet federal and State requirements to occur annually with quarterly updates. Preparation of quarterly updates can require up to three months.	Monitoring and updates to the budget occur daily. Automation improves timeliness of updates over Level 1.	Automation and use of MITA standard interface improves timeliness of updates over Level 2.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The information is based on financial cost data and cost estimates with standard inflation factor projection for future. Meets State requirements for accuracy.	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.	Use of MITA standard interface further improves accuracy of information; data accuracy is measured at 98%. Information can be shared with other agencies and States that adhere to MITA	

Formulate Budget				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
			standards.	
How accessible is the information used in this process?	The information is stored within Medicaid enterprise business units and is manually gathered and entered. Personnel information is stored within a human resources system; equipment within IT records, and supplies data within purchasing records.	Benefit information is stored within the MMIS and the state accounting system. Other operating expenses are stored in the state accounting system. More automation improves ability to access budget information.	Greater automation and use of MITA standard interface further improves accessibility to information.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	This is a manual effort and requires time and effort to complete. Cost to benefit ratio is relatively high.	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.	Use of MITA standard interface results in most effective formulation process. Cost to benefit ratio improves over Level 2.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Process meets state objectives for budget formulation.	Electronic creation and versioning provides more efficient formulation of the budget.	Use of standardized MITA interface further improves efficiency.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How useful or accurate are the results of this	This business process is a mix of manual and automated activities and is dependent	Increased automation improves accuracy of data extracted from systems and	Results improve over Level 2 with the use of MITA standard interface. Accuracy is	

Formulate Budget				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
process?	upon accuracy of data extracted from systems and accuracy of formulas within spreadsheet	accuracy of predictive modeling and forecasting tools.	measured at 98% or better.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Use of financial spreadsheet and automated processes for calculating and forecasting meets State goals for timeliness and accuracy of budget outcome. Satisfaction is negatively impacted by the number of manual processes.	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. Satisfaction is higher than at Level 1.	Use of MITA standard interfaces and COTS that use the MITA data standards further increases stakeholder satisfaction with the process. Satisfaction is higher than at level 2.	

Maintain Benefits/Reference Information: Business Capabilities

Maintain Benefits/Reference Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	This is a primarily manual process.	The agency uses tools to extensively analyze data to support maintenance of the benefit package/reference information.	MITA standardized data improves analysis and research required for maintenance of multiple benefit packages and reference information.	
What standards are used by this process?	State standards apply to reference data.	HIPAA mandated data exchange standards are used to define some reference data.	MITA data definitions are used to define reference data. MITA standard interfaces are used.	
Is collaboration with other agencies or entities used in this process?	There is limited collaboration.	Medicaid collaborates with Waiver programs, other agencies, and Managed Care Organizations (MCOs) through Memorandums of Understanding (MOUs) to define common reference data.	Full collaboration with other agencies to accept MITA standards to define reference data improves the process over Level 2.	

Maintain Benefits/Reference Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
How adaptable to change is this process?	As a manual process, changes are difficult to accommodate.	The use of automated tools allows more flexibility to adjust to change improves process over Level 2.	Maximum flexibility to make changes to reference data based on agency decisions.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	This is a manual effort and subject to delays.	Automation improves timeliness over that at Level 1.	Use of MITA standard data further improves timeliness beyond Level 2.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Data are sufficiently accurate.	Use of national data definitions improves accuracy rating over Level 1.	Accuracy further improves over Level 2 through use of MITA specified data definition standards. Accuracy measured at 99% or better.	
How accessible is the information used in this process?	Data sources are scattered, resulting in delays in access.	Due to increased automation, accessibility improves over Level 1.	Due to adoption of MITA standards, accessibility is improved over Level 2.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Maintenance involves a significant amount of manual processes resulting in a high cost to a low benefit ratio.	Standard Development Organizations provide scheduled updates. Staff is involved in adaptations and extensions of the standards provided.	Effectiveness is measured by number of staff who can focus on analysis of results of use of reference information.	

Maintain Benefits/Reference Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The manual process meets agency requirements but lacks in responsiveness to user needs.	Flexibility increases. Use of national data exchange standards (HIPAA) increases efficiency over Level 1.	Use of MITA standard interface in addition to State's flexibility in adoption of reference material maximizes efficiency for this process.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Meets agency objectives for maintenance of Benefit/Reference information, although it is difficult to determine the accuracy of the benefit/reference information.	Accuracy improves over Level 1 with use of national HIPAA requirements for data.	Reference data accuracy further improves over Level 2 with adoption of MITA data definitions and MITA standard interfaces.	
Business Capability Quality: Utility or Value to Stakeholders				

Maintain Benefits/Reference Information

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
<p>How satisfied are the stakeholders?</p>	<p>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.</p>	<p>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.</p>	<p>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 based on national and MITA best practices, improving stakeholder satisfaction over Level 2.</p>	

Maintain State Plan: Business Capabilities

Maintain State Plan				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	The process is primarily a manual function.	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.	MITA standard interface standardizes updates to the State Plan.	
What standards are used by this business process?	This is a free-form paper document update process.	The Medicaid enterprise has developed standard methodologies and information centralization to respond to changes in the State Plan. State Plan is under configuration and version control on the State’s portal.	The Medicaid enterprise adopts State MITA standard interfaces. This means its State Plan is interoperable with other State Plans.	
Is collaboration with other agencies or entities used by this process?	The Medicaid agency is a siloed organization and does not collaborate with other agencies and/or external entities.	The Medicaid enterprise has introduced intra-agency collaboration and external entity interfaces to centralize all data	All participating agencies adopt MITA standard interface for maintenance of the State Plan.	

Maintain State Plan				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
		necessary to maintain the State Plan. Local interface rules are used.		
How adaptable is this process to change?	All changes are manually processed. The process is slow and most changes are shown as addendum.	Electronic updates to State Plan are easier to adapt to change.	MITA standard interface changes are determined by MITA Governance. State-specific changes are easy to implement.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	All updates are manual and difficult to implement. Maintenance of State Plan is a year-round activity.	The electronic State Plan can be updated as necessary.	Standard MITA interface shortens the time required for updating State Plan.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The manual nature of this process increases the risk of unreliable and inaccurate information.	Implementation of standardized methodologies and centralized data allow for more accurate information.	Uses of standardized methodologies and centralized data have allowed information to be reliable and up-to-date. Accuracy is measured at 98% or better.	
How accessible is the information used in this process?	Information resides in multiple locations requiring time and effort to locate necessary information.	The Medicaid enterprise has introduced intra-agency collaboration and external entity interfaces to centralize all data necessary to maintain the State Plan. This provides for more accessible data.	Parties providing updates to State Plan use the MITA standard interface requirements.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the	This is a manual effort and	A mixture of manual and	Use of MITA standard	

Maintain State Plan				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
cost to perform this process compared to the benefits of the results?	requires time and effort to complete. Cost to benefit ratio is relatively high.	automated processes reduces the effort to maintain the State Plan as compared to Level 1. Cost to benefit ratio improves over Level 1.	interface results in most effective update process. Cost to benefit ratio improves over Level 2.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Process meets state objectives for maintaining State Plan.	Electronic creation and versioning provides more efficient maintenance of the State Plan.	Use of standardized MITA interface further improves efficiency.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The State Plan update process meets State and federal guidelines.	Updates are better controlled, more timely, and accurate as compared to Level 1.	MITA standard interface ensures accuracy of maintenance and allows for sharing of this information.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	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	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.	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	

Maintain State Plan				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	stakeholder satisfaction.		priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	

Manage 1099s: Business Capabilities

Manage 1099s				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	The process is primarily a manual process.	The process uses a mix of manual and automated processes.	The process is fully automated with rare exceptions.	
Does this process use standards?	The processes uses the federal standard format for the paper 1099.	The process uses the federal standard format for the electronic 1099. Data accessed includes national standards.	The process uses MITA standard interfaces and the federal standard format for the electronic 1099.	
Is collaboration with other agencies or entities used by this process?	Programs are siloed and multiple 1099s may be created by different payment systems for the same provider.	The Medicaid enterprise has agreements for common processes to achieve economies of scale and increase coordination.	The Medicaid enterprise collaborates in accepting MITA standard interface for Manage 1099s.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	Timeliness of the process is not measured. Meets federal and State requirements to produce 1099s.	Meets goals for production of 1099s. Automation improves timeliness over Level 1.	Automation and the use of MITA standard interfaces increases timeliness over Level 2.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The manual nature of the process introduces errors, however, corrections are made and error rate is acceptable.	Error rate and corrections decrease due to increase in automation and inter-agency agreements.	Information adheres to MITA standard interface specifications which improves accuracy over Level 2.	

Manage 1099s				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
			Accuracy is measured at 98% or better.	
How accessible is the information used in this process?	Accessibility is hampered by the number of sources to be searched for payment data.	Accessibility improves over Level 1 due to introduction of automation.	Accessibility improves over Level 2 due to automation and the use of MITA standard interfaces.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	The process meets agency budget objectives.	Less effort is required increasing cost effectiveness over Level 1.	Less effort to produce 1099s is needed than at level 2, but more focus is on quality control.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process is manually intensive. Activity peaks at year-end when 1099 production is scheduled.	Process is more efficient than at Level 1 due to automation.	Process is more efficient than Level 2 due to MITA standard interfaces.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The process meets agency goals for numbers of 1099s produced on schedule, but manual processes may lead to inaccuracies.	The process meets the Medicaid enterprise's goals for numbers of 1099s produced on schedule with reduced error rate.	The process meets to Medicaid enterprise's goals for numbers of 1099s produced on schedule, inter-agency collaboration, and reduction in error rate.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Manual processes and duplicative/erroneous reporting negatively impacts stakeholder	Stakeholder satisfaction improves over Level 1, due to automation and resulting reduction in	Stakeholders are more satisfied than at Level 2 due to the use of MITA standard interfaces	

Manage 1099s

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	satisfaction.	errors.	increasing efficiency and accuracy.	

Manage FFP for MMIS: Business Capabilities

Manage FFP for MMIS				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
How manual or automated is this business process?	This process relies on significant manual collection and handling of data obtained from various sources. Sources of data contain details of expenditures for the Design, Development and Installation (DDI) or operation of the MMIS. Sources include Human Resources, data center, and accounts payable.	The State Medicaid enterprise has implemented 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 and Advance Planning Document (APD).	At this level, the Medicaid enterprise has automated most activities to the extent feasible and uses MITA standard interfaces.	
What standards are used by this business process?	State uses local standards for accessing and extracting data. Much of the information is non-standard.	State has implemented standard methodologies to enable organized development and management of FFP reporting requirements.	The process uses MITA standard interface for extracting data and producing results.	
Is collaboration with other agencies or entities used by this process?	The Medicaid agency is a siloed organization and must request information	Agencies have a Memorandum of Understanding (MOU)	Other agencies and external entities agree to accept MITA standard	

Manage FFP for MMIS				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	individually from other agencies or external entities.	governing requests for information. Data is standardized per State specifications to better collaborate with other agencies and external entities.	interfaces, which further support collaboration.	
How adaptable is this process to change?	The process relies heavily on manual manipulation of information and does not adapt easily to change in reporting requirements.	The Medicaid enterprise has introduced automation and standardization and is able to handle some changes via flexible table updates.	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.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	Timeliness of responses to inquiries and data reporting is indeterminate. It takes several weeks to extract and manipulate data to produce standard reports requesting FFP for MMIS (e.g., CMS 64) or for APD.	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.	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.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this	The manage FFP business process is a manual process that	Data centralization and standardization provide more	Data centralization and standardization is in place	

Manage FFP for MMIS				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
process?	can lead to inaccuracies in data.	accurate information to manage the reporting of FFP for MMIS.	providing more fully automated and accurate information to manage the reporting of FFP for MMIS. Accuracy is measured at 98% or better.	
How accessible is the information used in this process?	The process is a cyclical process that requires multiple efforts to access information from many sources.	The data centralization and standardization of the information for determining FFP is more accessible.	Data centralization and use of MITA standard interface improves access to data needed to determine the FFP for MMIS.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	The manual nature of the process is time consuming and requires multiple iterations for documenting the FFP for MMIS.	The centralization and standardization of the information and automation of access reduce the effort of documenting the FFP for MMIS.	Data centralization and use of MITA standard interfaces provide a cost effective and streamlined process for documenting the FFP for MMIS.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The business process results meet State and federal requirements but require continuous manual efforts throughout the period of production of information for the report.	The data centralization and standardization of the information increases the efficiency of documenting FFP for MMIS.	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.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The manual nature of the process negatively impacts accuracy and may cause inaccuracies in the	The data centralization and standardization of the	Data centralization and use of MITA standard interfaces	

Manage FFP for MMIS				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	calculation of FFP for MMIS. State and federal audits discover errors in the process results.	information increases the accuracy of the data used in managing the FFP and the error rates are reduced.	provide an accurate and streamlined process for managing the FFP for MMIS. The error rates are less than 2%.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	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.	Medicaid Enterprise begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	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 based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	

Manage Program Information: Business Capabilities

Manage Program Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
General Description of Capabilities				
Is this process manual or automated?	Reports used to manage program information are not automatically distributed. Technical staff are required as an interface for information requests.	Some automation has been implemented resulting in business users having the capability of accessing information directly.	Business users have direct and dynamic access to centralized and federated data.	
Does this process use standards?	Local data standards are often duplicative. Data requests and results require manipulation to compensate for data variances.	State adoption of HIPAA data requirements increases the uniformity of data.	Adoption of MITA data models increases standardization of data. Requests for information can be sent to other states that also adhere to MITA standards.	
Does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	No collaboration. The Medicaid enterprise focuses on accessing information in its domain.	The Medicaid enterprise collaborates with other state agencies who agree on standards for a common data store, access rights, and security.	The Medicaid enterprise collaborates with any other entity that enters into agreements to adhere to MITA interface requirements, security protocols, and privacy rules.	
Business Capability Quality: Timeliness of Process				

Manage Program Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
How timely is this end-to-end process?	<p>The process is subject to long delays depending on the complexity of the request and the availability of technical staff.</p> <p>Since most requests have to be processed by a limited number of technical staff, requests may take several weeks to complete.</p>	<p>Use of Commercial Off The Shelf (COTS) products and tools dramatically improves the turnaround time to produce program information.</p> <p>Since business staff is able to perform some of their own inquiries, timeliness is generally improved over Level 1.</p>	<p>Use of MITA standards further reduces the time required to produce the desired result.</p> <p>Simple results created by individual business users require 30 minutes or less. Complex request created by business or technical staff require 1 day or less.</p>	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	<p>Manual operation results in subjective selection of data to be used. There are many known discrepancies in the data. Data must either be scrubbed prior to the processing, or analysis is required after result is produced to explain discrepancies.</p>	<p>Accuracy and consistency of data used in the process improve over Level 1. Use of COTS packages and HIPAA data standards increases reliability of data.</p>	<p>Use of MITA standardized interfaces and data standards ensures accuracy of data. Data accuracy is measured as 95%.</p>	
How accessible is the information used in this process?	<p>This process relies on information stored in operational and historical data stores. Information is not readily available. Requests must be scheduled to fit into the operational schedule.</p>	<p>The process uses on-line access to data. Use of COTS packages, tools, and HIPAA compliant data improves accessibility.</p>	<p>Immediate access to standardized data is available further improving accessibility over Level 2.</p>	
Business Capability Quality: Cost Effectiveness				

Manage Program Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
What is the ratio of the cost to perform this process compared to the benefits of the results?	The process meets State budget guidelines.	Cost-effectiveness improves over Level 1 through the use of automation and HIPAA data standards.	The process maximizes time of tactical and strategic staff to obtain answers critical to planning and policy decisions. The process demonstrates the improvement value projected by the Medicaid enterprise. Cost-effectiveness improves over Level 1.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process relies primarily on staff to manually perform actions. There is inherent inefficiency in submitting business requests to technical staff to produce results. Data inconsistency results in need to request a repeat of the inquiry.	Process efficiency greatly improves through automation and HIPAA data standards. In addition, business areas can manage many of their own inquiries.	Process efficiency further improves due to use of MITA interface standards which significantly reduces data errors and redundancies.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The process meets State and Federal expectations regarding results.	Additional automation produces more accurate results than at Level 1.	Use of MITA interface standards further improves accuracy of results over Level	

Manage Program Information				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	<p>Workarounds are applied to compensate for inconsistencies in data.</p> <p>Lack of data standards and manual processes can adversely impact accuracy.</p>		2.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	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 based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	

Manage Rate Setting: Business Capabilities

Manage Rate Setting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this business process primarily manual or automated?	The process is primarily manual.	The process is a mix of manual and automated activities. Information is received from multiple sources.	The process is primarily automated. Messages are exchanged with trading partners to obtain information.	
Does this business process use standards?	Standards are limited to the data standards enforced by the Medicaid enterprise.	Adoption of HIPAA standards improves standardization of data used for rate setting which supports comparability with other payers.	MITA standard interface ensures the comparability of data used for rate setting across entities accepting the standard.	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The process meets State target dates for periodic updates to reimbursement rates.	Increased automation shortens the time required to complete rate setting functions, improving timeliness over Level 1.	Use of MITA standard interface and data standards further reduces time required for rate setting, improving timeliness over Level 2.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual operation results in subjective selection of data to be used.	Accuracy and consistency of data used in the process improves over Level 1 due to increased automation and HIPAA and other data	Use of MITA standardized interfaces and data standards ensures accuracy of data. Data accuracy is measured as 99%.	

Manage Rate Setting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
		standards.		
How accessible is the information used in this process?	Access to data is controlled manually. Data is stored in multiple locations and different standards may apply.	Access to data improves over Level 1 due to increased automation and introduction of HIPAA and other data standards. The process uses on-line access to data.	The process utilizes MITA standards for its interfaces and for processing. The process has immediate access to standardized data.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Manual processes and lack of standards negatively impact cost-effectiveness.	Automation and HIPAA and other data standards increase cost-effectiveness over Level 1.	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.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processes create inefficiencies.	Use of automation, HIPAA, and other data standards increase efficiency over Level 1.	Use of MITA standard data improves comparability of data used in the setting of rates. Automation allows staff	

Manage Rate Setting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
			to focus on strategic aspects of rate setting and Medicaid enterprise policy regarding rates.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Manual inputs into system and payment rates are manually validated resulting in potential inconsistency or invalid rates.	Improvements in the rate setting process, including automation, results in more accurate rates that encourage provider participation while helping to maintain cost controls.	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.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	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 based on national and MITA best practices, improving stakeholder satisfaction	

Manage Rate Setting

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
			over Level 2.	

Manage State Funds: Business Capabilities

Manage State Funds				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this business process primarily manual or automated?	The process is primarily manual. Data is stored in electronic format, but the analysis and application of decisions regarding allocations and reporting are manual.	A mixture of manual and automated process is used. Use of Commercial Off The Shelf (COTS) products to support Medicaid enterprise financial functions improves ability to access information, analyze, and make decisions regarding allocation and reporting.	The process is primarily automated due to improvements in COTS products and use of MITA standardized data.	
Does this business process use standards?	Standards may be siloed within systems.	The Medicaid enterprise develops standards.	Management of State funds improves over Level 2 with the use of MITA standard interfaces.	
Does the Medicaid agency collaborate with other agencies or entities in performing this process?	Some collaboration is required in the allocation of federal funds where non-Medicaid agencies are involved.	Memorandum of Understanding (MOU) with other agencies provides a legal basis for allocation of funds.	MITA aligned Service Level Agreements with other agencies improve collaboration.	
Business Capability Quality: Timeliness of Process				

Manage State Funds				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
How timely is this end-to-end process?	The manual process requires the full amount of time available, i.e., month, quarter, annual.	Less time is required than Level 1.	The process takes less time than Level 2.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	The manual methodology builds in redundancy to validate allocation formulas and totals. Errors may occur due to the primarily manual process.	Some automation improves accuracy and reduces errors.	Use of MITA standard interface further improves accuracy.	
How accessible is the information used in this process?	The process requires significant manual access to data in a variety of sources.	Data is readily available to authorized users.	Data is immediately accessible.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Meets Medicaid enterprise goals for completing allocation of state funds. Cost benefit ratio may not be able to be calculated.	Automation frees some time for staff to focus on analysis of the data, projections, and recommendations for improvements in allocation formulas.	MITA standard interfaces and improvements in COTS further increase the cost-effectiveness over Level 2.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Minimally meets federal requirements for management of state funds. Manual processes create inefficiencies.	Automated processes results in improvements in utilization of staff who are proactively managing state funds. Automation increases efficiency over Level 1.	Efficiency improves further through use of MITA standard interface which ensures consistency among the various State funds.	
Business Capability Quality: Accuracy; Usefulness of Process Results				

Manage State Funds				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
How accurate are the results of this process?	Manual processes can negatively impact accuracy.	Automation reduces error rates and makes it easier to detect and correct errors.	MITA standard interfaces further increase the accuracy over Level 2.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	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 based on national and MITA best practices, improving stakeholder satisfaction over Level 2.	

Perform Accounting Function: Business Capabilities

Perform Accounting Function				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Descriptions				
This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Is this business process primarily manual or automated?	The accounting function is a mix of manual and automated activities using locally developed applications.	The accounting function uses a mix of manual processes and Commercial Off The Shelf (COTS) products.	Periodic reporting is highly automated.	
Does this business process use standards?	Complies with CFR 45, Cash Management Act, Governmental Accounting Standards Board (GASB) standards.	Complies with CFR 45, Cash Management Act, GASB standards and Generally Accepted Accounting Principles (GAAP) COTS packages are certified compliant with these standards.	Complies with CFR 45, Cash Management Act, GASB standards and GAAP. Uses MITA standard interface.	
Does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	Collaboration includes manual processes and is limited and ad hoc. Collaboration with other agencies is limited to the sharing of reporting results. The MMIS operational functions are shared across all Medicaid enterprise agencies.	Collaborative efforts are more structured and widespread and strategic in nature.	Collaboration is further improved by the use of data definitions and MITA standard interfaces.	

Perform Accounting Function				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The semi-automated process struggles to meet deadlines.	Less time is required than at Level 1. automated processes.	Less time is required than at Level 2. standard interface.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual operation results in subjective selection of data to be used. Conflicts of data occur frequently. Validation is via locally developed applications. Error detection and correction is manual.	Accuracy and consistency of data used in the process are improved due to the use standards and increased automation.	Use of MITA standardized interfaces and data definitions ensures even greater improvement in the accuracy of data. Data is easily reconciled among various reports. Data accuracy is measured at 99%.	
How accessible is the information used in this process?	Access to data is controlled manually. Data access is limited and not readily shared with stakeholders.	The process uses on-line access to data. Real-time data access may be limited creating timeliness issues.	The process has real time access to standardized data.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	The process meets State budget guidelines. Cost benefit ratio may not be able to be calculated.	Through the use of automation and other process improvements, the cost benefit ratio improves.	The process demonstrates further improvement value desired by the Medicaid enterprise.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this	The process relies primarily on	Automated processes results	Meets Medicaid enterprise	

Perform Accounting Function				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
process?	staff to perform actions.	in higher efficiency.	goals for improvement in efficiency and complies with MITA conformance standard for this process.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The process meets minimal State and Federal expectations regarding accuracy of results.	Reduction in errors and improved consistency of results increase usefulness of the process.	Accuracy and consistency are further improved with use of MITA standard interface.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	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 based on national and MITA best practices, improving	

Perform Accounting Function				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
			stakeholder satisfaction over Level 2.	

Develop and Manage Performance Measures Reporting: Business Capabilities

Develop and Manage Performance Measures Reporting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
<p>Business Capability Descriptions</p> <p>This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.</p>				
How manual or automated is this business process?	The process is manual and duplicated in multiple areas within the organization.	The process is a mix of manual and automated processes to gather data and perform calculated outcomes measures.	The process if fully automated with few exceptions.	
Does this process use standards?	Standardized measures developed by the federal or state governments have been applied to a few Medicaid processes and programs. There may be inconsistencies among agency divisions.	Standardized industry performance measures in addition to federal or state performance measures have been applied to many of the Medicaid enterprise processes and programs.	The process uses MITA standardized interfaces and data definitions to standardize performance measures for all Medicaid enterprises and programs.	
How are data used in this process verified?	Data is manually verified prior to release.	Data verification prior to release is a mix of manual and automated processes.	Data verification is fully automated.	
Are performance measures published?	Measures are produced manually and distributed to other parties	Measurements are electronically published.	Based on use of MITA standard interfaces and data definitions States	

Develop and Manage Performance Measures Reporting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	responsible for the activity.		may share outcome measures with other States and federal agencies..	
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	This process occurs periodically (weekly, monthly, quarterly, and annually) to meet state and federal timeliness requirements.	Automated receipt of data insures a more timely availability of information than found at level 1.	Information can be refreshed daily on dashboard. Periodicity of posting is up to the state.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	There are some issues regarding data accuracy and completeness and some calculation errors occur.	Internal standardization of data, use of HIPAA data exchange standards, and increased use of automation reduces inaccuracies in data.	Use of standard MITA interface further reduces data errors.	
How accessible is the information used in this process?	Access to data to perform measurement is primarily a manual process. Communication is limited to paper, email, Compact Disc (CD) or publications.	Access to data to perform measurement is primarily through an automated process. Communication occurs through email, Compact Disc (CD) or publication on State's website.	Performance measurement is built into individual business processes and also consolidated into state-level dashboards. Access to data using MITA standard interface which increases accessibility.	
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	The business process is manual and may take several weeks to gather specified data for	The business process is mix of automated and manual processes with reduced cost to produce	Use of MITA standard interfaces and inclusion of performance measures in individual	

Develop and Manage Performance Measures Reporting				
Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	calculation. Accuracy of calculations is manually verified. Publication of outcomes measurement is valuable to State in monitoring efforts.	data and increased value to the State as result of publication of outcomes to public. Automation improves effectiveness of performance measures.	business processes increases cost-effectiveness of this process.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processing, lack of coordination with other processes, duplicative work may result in many opportunities to create or improve efficiency.	Increased automation, coordination with other processes, and introduction of standards reduce duplicative work and create more efficiency.	Use of MITA standards increases efficiency of this process.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Manual review and verification of accuracy of calculations is needed prior to publication. Manual processes may be error prone.	Less manual review and verification of accuracy of calculations is needed prior to publication due to automation resulting in improved accuracy of the results.	Accuracy increases over level 2 due to the use of MITA standard interfaces.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is negatively impacted by manual processes, with few resources dedicated to	Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations	Medicaid enterprise conducts internal and external audits/focus groups which take into	

Develop and Manage Performance Measures Reporting

Capability Question	Level 1	Level 2	Level 3	Level 4 & 5
	<p>improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.</p>	<p>and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.</p>	<p>consideration the results of its previous research along with other national standards to identify additional stakeholder expectations and priorities. Improvements are made based on national and MITA best practices, improving stakeholder satisfaction over Level 2.</p>	

Provider Management

PM Enroll Provider: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
1. Decisions on application may take several days but within State regulations.	Process is more timely than Level 1.	Turnaround time on application decision can be immediate .	Turnaround time is immediate including access to clinical data .	Turnaround time is immediate, on a national scale .
Data Access and Accuracy				
2. Application data and format are non standard .	Application data are standardized within the agency.	Application data interfaces are standardized nationally using MITA standards .	Medicaid Provider Registries are federated with regional data exchange networks.	Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally.
3. Some enrollment records are stored electronically but storage is not centralized .	Enrollment records for different programs are stored separately .	Enrollment records are stored in either a single Provider Registry or federated Provider Registries that can be accessed by all participants.		
4. Provider data , including ID and taxonomy, is not comparable across provider types and programs , reducing ability	Providers have different IDs per program and within Medicaid program and cannot be cross-matched.	The NPI is the identifier of record.		

PM Enroll Provider: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
5. to monitor performance or detect fraud and abuse.	Staff perform queries into stored Medicaid provider and claims data to identify providers with specialties and service indicators indicating potential for enrollment as primary care, disease management, and waiver providers.			
6.	Although data comparability is improved , performance data is only periodically measured and requires sampling and statistical calculation.			
7.		Providers, members, and state enrollment staff have secure access to appropriate data on demand.	Authorized, authenticated parties have virtual, instant access to provider data locally .	Authorized, authenticated parties have virtual, instant access to provider data, nationally .
8.			Access to clinical data improves capability to select providers that meet quality standards.	
Effort to Perform; Efficiency				
9. Staff contact external and internal credentialing and	Verifications are a mix of manual and automated steps.	Manual steps may continue only for exceptions .		

PM Enroll Provider: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>verification sources via phone, fax.</p> <p>10.</p>	<p>Enrollment processes continue to be handled by siloed programs according to program-specific rules.</p>	<p>Medicaid and sister agencies collaborate on provider enrollment processes.</p>		
<p>11.</p>	<p>Providers can submit on paper and electronically via a portal which improves turnaround time.</p>	<p>Most applications are submitted electronically. Electronic applications adhere to MITA standard interface requirements.</p>		
<p>12. A large staff is required to meet targets for manual enrollment of providers.</p>				
<p>13.</p>			<p>Any data exchange partner can send a notification regarding a provider enrolled with the state Medicaid program.</p>	<p>Any data exchange partner can send a notification regarding a provider enrolled with any program in the U.S.</p>
<p>14.</p>			<p>External and internal validation sources automatically send</p>	<p>Nationally interoperable validation sources</p>

PM Enroll Provider: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
			notice of change in provider status, eliminating the need to re-verify; supports detection of sanctioned providers in real time.	automatically send notice of change in provider status, eliminating the need to re-verify; supports detection of sanctioned providers in real time anywhere in the U.S.
Cost-Effectiveness				
15. Requires large numbers of staff .	Process requires fewer staff than Level 1 and produces better results.	Process requires fewer staff than Level 2 and improves on results.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who monitor provider network performance.	Same as Level 4 with additional benefit of access to sources of information nationally .
16.		Shared processes and inter-agency collaboration contribute to streamline the process.		
Accuracy of Process Results				
17. Much of the application information is manually validated .	Automation of some business rules improves accuracy of validation and verification .	All verifications can be automated and conducted via standardized interfaces.		Same as Level 4, on a national scale .
18. Decisions may be	Decisions more consistent than level 1 .	Consistent enrollment rules ,		

PM Enroll Provider: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>inconsistent.</p> <p>19. Due to limited monitoring and re-verification of enrolled providers' status, sanctioned providers may continue to be enrolled.²</p> <p>20.</p> <p>21.</p> <p>22.</p>	<p>The emphasis on managed care and waiver programs encourages more scrutiny of and reporting to national databases.</p>	<p>standardized data available from a single source support continuous performance measures that can be used to adjust rates in real time.</p> <p>The agency sends verification inquiries to any other agency regarding the status of a provider.</p> <p>The quality of the provider network is improved.</p>	<p>Prospective monitoring of program integrity during adjudication improves detection of fraud and abuse, resulting in timelier sanctioning.</p> <p>Performance measures can be shared via federated Provider Registries.</p> <p>Clinical data can be accessed and monitored for measuring</p>	<p>Performance measures can be shared via federated Provider Registries, nationally.</p>

PM Enroll Provider: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
23.			performance.	
Utility or Value to Stakeholders				
24. Focus is on building a provider network that meets needs of the members.	In managed care and waiver settings, guidelines ensure adequacy of network (i.e., ratio of number, type, and location of provider to size and demographics of member population).	Members interact directly with providers and can view provider profiles and locations; make informed choices.	Providers and care managers access standardized Provider Registries and view clinical performance indicators to make informed decisions re provider selection, provider referrals.	Same as Level 4, on a national scale , where appropriate.
25. Staff do not have time to focus on cultural and linguistic compatibility, member satisfaction, or provider performance.	Cultural and linguistic matches are made.	Cultural and linguistic indicators improve selection of appropriate providers.		
26.	Members are assigned to PCPs to coordinate their care.			
27.		Provider and member satisfaction improves because of speed and accuracy of enrollment process.		

PM Disenroll Provider: Business Capabilities¹

PM Disenroll Provider: Business Capabilities ¹				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				

1. <i>Most requests to disenroll provider are received and responded to manually via phone, fax, USPS.</i>	<i>Requests to disenroll provider are automated via AVRS, Web portal, EDI within an agency using agency standards for messages.</i>			
2.	<i>Responses to requests are immediate.</i>	<i>Responses are immediate.</i>	<i>Responses are immediate.</i>	<i>Turnaround time is immediate, on a national scale.</i>
3.		<i>Information can be shared among authorized entities within the state.</i>	<i>Information, including clinical, can be shared among authorized entities within the state.</i>	
<i>Data Access and Accuracy</i>				
4. <i>Information is researched manually.</i>	<i>Automation improves access and accuracy.</i>	<i>Data inquiry messages use MITA standard interfaces, improving accuracy.</i>	<i>Medicaid Provider Registries are federated with regional data exchange networks.</i>	<i>Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally.</i>
5.		<i>Collaborating agencies using the MITA standard interfaces can exchange data on registered providers.</i>	<i>All authorized data exchange partners can access provider information.</i>	
6.	<i>Access is via Web portal and EDI channels.</i>			
7. <i>There may be inconsistencies in responses.</i>				
<i>Effort to Perform; Efficiency</i>				
8. <i>Staff research and respond to requests manually.</i>	<i>Responses to requests to disenroll provider are</i>	<i>Provider information is continuously refreshed.</i>	<i>Access to clinical information is available.</i>	<i>Automated access to information nationally further</i>

9.	<i>automated.</i> <i>Fewer staff required to support.</i>	<i>Further reduction in staff support.</i>		<i>improves efficiency.</i>
10.		<i>One stop shop for agencies who share providers.</i>		
<i>Cost-Effectiveness</i>				
11. <i>Requires research staff.</i>	<i>Automation leads to fewer staff than Level 1.</i>	<i>Use of MITA standard interfaces streamlines the disenrollment process.</i>	<i>Regional, federated provider registries eliminate redundant overhead, i.e., one-stop shop inquiries.</i>	<i>Gains of Level 4 are further improved by access to provider information on a national basis.</i>
12.	<i>Number of disenrollment requests per day increases significantly.</i>			
<i>Accuracy of Process Results</i>				
13. <i>Responses are manually validated, e.g., via call center audits; stakeholder satisfaction survey.</i>	<i>Automation improves accuracy of responses.</i>	<i>MITA standard interfaces produce consistent responses to requests.</i>	<i>Incorporation of clinical data improves accuracy of some responses.</i>	<i>Same as Level 4, on a national scale, where authorized.</i>
14. <i>Process complies with agency requirements.</i>				
<i>Utility or Value to Stakeholders</i>				
15. <i>Requesters receive the information they need.</i>	<i>Requesters receive immediate responses.</i>	<i>Requesters have a one-stop shop to access collaborating agencies to obtain information on a provider.</i>	<i>Requesters benefit from access to clinical data as an added value.</i>	<i>Same as Level 4, on a national scale, where authorized.</i>

PM Inquire Provider Information: Business Capabilities¹



Level 1	Level 2	Level 3	Level 4	Level 5
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<i>Business Capability Qualities: Timeliness of Process</i>				
1. Most requests for verification of provider information are received and responded to manually via phone, fax, USPS.	Requests for provider information are automated via AVRS, Web portal, EDI within an agency using agency standards for messages.			
2.	Responses to routine inquiries are immediate.	Responses are immediate.	Responses are immediate.	Turnaround time is immediate, on a national scale.
3.		Information can be shared among authorized entities within the state.	Information, including clinical, can be shared among authorized entities within the state.	
<i>Data Access and Accuracy</i>				
4. Information is researched manually.	Automation improves access and accuracy. Access is via Web portal and EDI channels.	Data inquiry messages use MITA standard interfaces, improving accuracy.	Medicaid Provider Registries are federated with regional data exchange networks.	Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally.
5.		Collaborating agencies using the MITA standard interfaces can exchange data on registered providers. One stop shop for agencies who share providers.	All authorized data exchange partners can access provider information.	
6. There may be inconsistencies in responses.				
<i>Effort to Perform; Efficiency</i>				
7. Staff research and respond	Responses to requests to	Provider information is	Inquiries include summary	Automated access to

<p><i>to requests manually.</i></p> <p>8. Labor intensive business process.</p>	<p><i>inquire about provider information are automated.</i></p> <p><i>Fewer staff required to support.</i></p>	<p><i>continuously refreshed.</i></p> <p><i>Further reduction in staff support.</i></p>	<p><i>clinical information relating to provider performance and quality of care.</i></p>	<p><i>information nationally further improves efficiency.</i></p>
<i>Cost-Effectiveness</i>				
<p>9. Requires research staff.</p> <p>10.</p>	<p><i>Automation leads to fewer staff than Level 1.</i></p> <p><i>Number of responses per day increases significantly.</i></p>	<p><i>Use of MITA standard interfaces streamlines the inquiry process.</i></p>	<p><i>Regional, federated provider registries eliminate redundant overhead, i.e., one-stop shop inquiries.</i></p>	<p><i>Gains of Level 4 are further improved by access to provider information on a national basis.</i></p>
<i>Accuracy of Process Results</i>				
<p>11. Responses are manually validated, e.g., via call center audits; stakeholder satisfaction survey.</p> <p>12. Process complies with agency requirements.</p>	<p><i>Automation improves accuracy of responses.</i></p>	<p><i>MITA standard interfaces produce consistent responses to inquiries.</i></p>	<p><i>Incorporation of clinical data improves accuracy of some responses.</i></p>	<p><i>Same as Level 4, on a national scale, where authorized.</i></p>
<i>Utility or Value to Stakeholders</i>				
<p>13. Requesters receive the information they need.</p>	<p><i>Requesters receive immediate responses.</i></p>	<p><i>Requesters have a one-stop shop to access collaborating agencies to obtain information on a provider.</i></p>	<p><i>Requesters benefit from access to clinical data as an added value.</i></p>	<p><i>Same as Level 4, on a national scale, where authorized.</i></p>

PM Manage Provider Communication: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. Manual and semi-automated steps may require some days to complete response.</p> <p>2.</p>	<p>Provider requests and responses are automated via Web, AVRS, EDI with date stamp and audit trail.</p>	<p>Inquiries and responses using MITA standard interfaces are immediate.</p>	<p>Inquiry and response, and communications sent by the agency are immediate.</p> <p>Interaction between provider clinical data and the agency is automatic.</p>	<p>Turnaround time is immediate, on a national scale.</p>
<i>Data Access and Accuracy</i>				
<p>3. Responses are made manually and there may be inconsistency and inaccuracy (within agency tolerance level).</p> <p>4. Provider communication is not coordinated among multiple, siloed programs and not systematically triggered by agency-wide processes.</p> <p>5.</p>	<p>Automated responses increase accuracy. Access is via Web portal and EDI channels.</p>	<p>Requests and responses are standardized as MITA interfaces, improving accuracy.</p> <p>Provider information is accessed via either a single Provider Registry or federated Provider Registries. Provider information belonging to different entities can be virtually consolidated to form a single view.</p>	<p>Medicaid Provider Registries are federated with regional data exchange networks, improving access channels. Responses are standardized.</p> <p>The provider clinical record information can trigger messages to and from the</p>	<p>Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally. Responses are immediately available.</p> <p>Indicator algorithms triggered by RHIO traffic, clinical record updates, and personal health</p>

PM Manage Provider Communication: Business Capabilities¹

PM Manage Provider Communication: Business Capabilities ¹				
Level 1	Level 2	Level 3	Level 4	Level 5
			<p><i>provider and the Medicaid agency. For example, if the provider enters information into the clinical record regarding the disease state of the patient, the Medicaid system can send information to the provider re candidacy of the patient for a disease management program.</i></p>	<p><i>record entries can trigger communication messages directly to the provider.</i></p>
<i>Effort to Perform; Efficiency</i>				
<p><i>6. Staff research and respond to requests manually.</i></p>	<p><i>Responses to routine provider requests are automated.</i></p>	<p><i>Information requested by provider is continuously refreshed.</i></p>	<p><i>Access to clinical information can improve efficiency especially in alert messaging.</i></p>	<p><i>Automated access to information nationally further improves efficiency. Medicaid provider registry is federated with RHIOs which enables the Medicaid agency to reach all targeted providers statewide to receive general communiqués or public health alerts.</i></p>
<p>7.</p>		<p><i>Collaboration among agencies achieves a one-stop shop for provider inquiries, e.g., mental health provider requests enrollment status from Medicaid, Mental Health Department, MCO.</i></p>		
<p>8.</p>		<p><i>Provider registries use</i></p>		

PM Manage Provider Communication: Business Capabilities¹

PM Manage Provider Communication: Business Capabilities ¹				
Level 1	Level 2	Level 3	Level 4	Level 5
		<i>standardized contact data, including NPI address standards, to alleviate postal delivery failures.</i>		
<i>Cost-Effectiveness</i>				
<i>9. Requires large research staff.</i>	<i>Automation leads to fewer staff than Level 1.</i>	<i>Use of MITA standards and collaboration among agencies increases effectiveness.</i>	<i>Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who monitor provider satisfaction with responses to inquiries.</i>	<i>Gains of Level 4 are further improved by access to provider information on a national basis.</i>
<i>10.</i>	<i>Number of responses per day increases significantly.</i>			
<i>Accuracy of Process Results</i>				
<i>11. Responses are manually validated, e.g., call center audits; provider satisfaction survey.</i>	<i>Automation improves accuracy of responses.</i>	<i>MITA standard interfaces specify requests and response messages and are used by collaborating agencies in the state.</i>	<i>Access to clinical data improves accuracy of targeted alerts.</i>	<i>Same as Level 4, on a national scale, where authorized.</i>
<i>12. May encounter obstacles to delivery, e.g., incorrect or lack of contact information.</i>				
<i>13. Process complies with agency requirements.</i>				

PM Manage Provider Communication: Business Capabilities¹

PM Manage Provider Communication: Business Capabilities ¹				
Level 1	Level 2	Level 3	Level 4	Level 5
Utility or Value to Stakeholders				
<p>14. Providers receive the information they need.</p>	<p><i>Providers have no delay in obtaining responses.</i></p>	<p><i>Providers have a one stop shop to access collaborating agencies to obtain information.</i></p>	<p><i>Some inquiries/responses are replaced by automated messaging.</i></p>	<p><i>Same as Level 4, on a national scale, where authorized.</i></p>
<p>15. No emphasis on linguistic, cultural or competency-based considerations.</p>	<p><i>Provider communications improve in meeting linguistic, cultural, and competency goals, but require labor intensive intervention.</i></p>	<p><i>Use of electronic communications makes provision of linguistically, culturally, and competency appropriate messages more feasible and cost-effective.</i></p>		
<p>16.</p>	<p><i>Routine communications are created to meet the needs of managed care, waiver, atypical, and special program providers.</i></p>			

PM Manage Provider Grievance & Appeal: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Business Capability Qualities: Timeliness of Process</i>				
<p>1. <i>This is an all-manual process.</i></p> <p>2. <i>Confidential documents are transferred by certified mail.</i></p> <p>3.</p> <p>4. <i>Cases typically require months to complete.</i></p>	<p><i>Requests for provider information are automated via AVRS, Web portal, EDI within an agency.</i></p> <p><i>Documents are scanned and the case file is automated and can be shared among case workers.</i></p> <p><i>Responses to research questions within the agency are immediate.</i></p> <p><i>Overall timeline to resolve a case is shortened.</i></p>	<p><i>Case file is Web-enabled; information is shared among staff managing the case.</i></p> <p><i>Responses to research questions are immediate across all data sharing partners within the state.</i></p>	<p><i>Responses to research questions are immediate. Information, including clinical, is immediately and directly accessible.</i></p>	<p><i>Turnaround time of information gathering is immediate, on a national scale.</i></p>
<i>Data Access and Accuracy</i>				
<p>5. <i>Information is researched manually.</i></p> <p>6.</p>	<p><i>Automation improves access and accuracy.</i></p> <p><i>Access is via Web portal and EDI channels.</i></p>		<p><i>Medicaid Provider Registries are federated with regional data exchange networks.</i></p> <p><i>All authorized data exchange partners can access provider information, including clinical data.</i></p>	<p><i>Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally.</i></p>

PM Manage Provider Grievance & Appeal: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<p>7. <i>There may be inconsistencies in responses.</i></p> <p>8. <i>There are no standards for case data.</i></p>	<p><i>There is more consistency in the steps taken in the review and resolution process.</i></p> <p><i>Agency standards for inquiries are introduced.</i></p>	<p><i>Standard MITA interfaces improve accuracy of content.</i></p>		
<i>Effort to Perform; Efficiency</i>				
<p>9. <i>Staff research and maintain manually.</i></p> <p>10.</p> <p>11.</p>	<p><i>Responses to requests to verify provider case information are automated.</i></p>	<p><i>MITA standard interfaces standards are used for creation of a case and publication of results.</i></p> <p><i>MITA standard interfaces are also used for inquiry and response for acquisition of information needed to build the case.</i></p>	<p><i>Access to clinical information improves efficiency. Clinical data is automatically accessed to substantiate case findings.</i></p> <p><i>The original case against a provider may be triggered directly from the clinical record. This is a paradigm shift that introduces a new business process.</i></p>	<p><i>Automated access to information nationally further improves efficiency.</i></p> <p><i>Case researchers instantly know if there are case precedents in other states or agencies (a) for the provider in question, or (b) for similar types of cases.</i></p>

PM Manage Provider Grievance & Appeal: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
12.		<p><i>Medicaid collaborates with other health and human services agencies that manage appeals to create a one-stop shop model for both provider and consumer appeals.</i></p>	<p><i>Automated business rules that include clinical data lead to earlier resolution of cases.</i></p>	
<i>Cost-Effectiveness</i>				
<p><i>13. Process is labor-intensive. Results take several months.</i></p>	<p><i>Automation of some research steps reduces level of staffing required to manage a case.</i></p>	<p><i>Collaboration with sister agencies that conduct appeals cases increases cost-effectiveness.</i></p>	<p><i>Full automation of the process plus access to clinical data reduce staff requirements to a core team of professionals who monitor stakeholder satisfaction with responsiveness to inquiries.</i></p>	<p><i>Gains of Level 4 are further improved by access to provider information on a national basis.</i></p>
14.		<p><i>Standardization of input and case results allows staff to focus on analytical activities.</i></p>		
15.			<p><i>Regional, federated provider registries eliminate redundant overhead.</i></p>	

PM Manage Provider Grievance & Appeal: Business Capabilities¹

Level 1	Level 2	Level 3	Level 4	Level 5
<i>Accuracy of Process Results</i>				
<p>16. Terms of the settlement or results of the hearing are manually documented according to the administrative rules of the state.</p> <p>17. There may be inconsistencies between similar cases. Process complies with agency requirements.</p>	<p>Automation is introduced into the case management process. Results are documented and recorded automatically and can be accessed and reviewed as needed.</p>	<p>MITA standard interface improves accuracy of case results.</p>	<p>Incorporation of clinical data improves accuracy of final disposition of the case.</p>	<p>Gains of Level 4 are further improved by access to provider information on a national basis.</p>
<i>Utility or Value to Stakeholders</i>				
<p>18. Business process complies with agency and state requirements for a fair hearing and disposition.</p>	<p>The provider and the agency benefit from introduction of automation to speed up the case resolution.</p>	<p>Agencies benefit from introduction of MITA standard interfaces. Providers benefit from consistency and predictability of the process.</p>	<p>Use of clinical evidence reduces false positives and improves consistency of results.</p>	<p>Same as Level 4, on a national scale.</p>

State Specific

SS Perform Provider Enrollment Pre-Certification: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Qualities: Timeliness of Process				
1. Decisions on application may take several days but within State regulations.	Process is more timely than Level 1.	Turnaround time on application decision can be immediate .	Turnaround time is immediate including access to clinical data .	Turnaround time is immediate, on a national scale .
Data Access and Accuracy				
2. Application data and format are non standard .	Application data are standardized within the agency.	Application data interfaces are standardized nationally using MITA standards .	Medicaid Provider Registries are federated with regional data exchange networks.	Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally.
3. Some enrollment records are stored electronically but storage is not centralized .	Enrollment records for different programs are stored separately .	Enrollment records are stored in either a single Provider Registry or federated Provider Registries that can be accessed by all participants.		
4. Provider data , including ID and taxonomy, is not comparable across provider types and programs, reducing ability	Providers have different IDs per program and within Medicaid program and cannot be cross-matched.	The NPI is the identifier of record.		

SS Perform Provider Enrollment Pre-Certification: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
5. to monitor performance or detect fraud and abuse.	Staff perform queries into stored Medicaid provider and claims data to identify providers with specialties and service indicators indicating potential for enrollment as primary care, disease management, and waiver providers.			
6.	Although data comparability is improved , performance data is only periodically measured and requires sampling and statistical calculation.			
7.		Providers, members, and state enrollment staff have secure access to appropriate data on demand.	Authorized, authenticated parties have virtual, instant access to provider data locally .	Authorized, authenticated parties have virtual, instant access to provider data, nationally .
8.			Access to clinical data improves capability to select providers that meet quality standards.	
Effort to Perform; Efficiency				
9. Staff contact external and internal credentialing and	Verifications are a mix of manual and automated steps.	Manual steps may continue only for exceptions .		

SS Perform Provider Enrollment Pre-Certification: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>verification sources via phone, fax.</p>				
10.	<p>Enrollment processes continue to be handled by siloed programs according to program-specific rules.</p>	<p>Medicaid and sister agencies collaborate on provider enrollment processes.</p>		
11.	<p>Providers can submit on paper and electronically via a portal which improves turnaround time.</p>	<p>Most applications are submitted electronically. Electronic applications adhere to MITA standard interface requirements.</p>		
12. A large staff is required to meet targets for manual enrollment of providers.				
13.			<p>Any data exchange partner can send a notification regarding a provider enrolled with the state Medicaid program.</p>	<p>Any data exchange partner can send a notification regarding a provider enrolled with any program in the U.S.</p>
14.			<p>External and internal validation sources automatically send</p>	<p>Nationally interoperable validation sources</p>

SS Perform Provider Enrollment Pre-Certification: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
			notice of change in provider status, eliminating the need to re-verify; supports detection of sanctioned providers in real time.	automatically send notice of change in provider status, eliminating the need to re-verify; supports detection of sanctioned providers in real time anywhere in the U.S.
Cost-Effectiveness				
15. Requires large numbers of staff .	Process requires fewer staff than Level 1 and produces better results.	Process requires fewer staff than Level 2 and improves on results.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who monitor provider network performance.	Same as Level 4 with additional benefit of access to sources of information nationally .
16.		Shared processes and inter-agency collaboration contribute to streamline the process.		
Accuracy of Process Results				
17. Much of the application information is manually validated .	Automation of some business rules improves accuracy of validation and verification .	All verifications can be automated and conducted via standardized interfaces.		Same as Level 4, on a national scale .
18. Decisions may be	Decisions more consistent than level 1 .	Consistent enrollment rules ,		

SS Perform Provider Enrollment Pre-Certification: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>inconsistent.</p> <p>19. Due to limited monitoring and re-verification of enrolled providers' status, sanctioned providers may continue to be enrolled.²</p> <p>20.</p> <p>21.</p> <p>22.</p>	<p>The emphasis on managed care and waiver programs encourages more scrutiny of and reporting to national databases.</p>	<p>standardized data available from a single source support continuous performance measures that can be used to adjust rates in real time.</p> <p>The agency sends verification inquiries to any other agency regarding the status of a provider.</p> <p>The quality of the provider network is improved.</p>	<p>Prospective monitoring of program integrity during adjudication improves detection of fraud and abuse, resulting in timelier sanctioning.</p> <p>Performance measures can be shared via federated Provider Registries.</p> <p>Clinical data can be accessed and monitored for measuring</p>	<p>Performance measures can be shared via federated Provider Registries, nationally.</p>

SS Perform Provider Enrollment Pre-Certification: Business Capabilities¹

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	Level 2	Level 3	Level 4	Level 5
23.			performance.	
Utility or Value to Stakeholders				
24. Focus is on building a provider network that meets needs of the members.	In managed care and waiver settings, guidelines ensure adequacy of network (i.e., ratio of number, type, and location of provider to size and demographics of member population).	Members interact directly with providers and can view provider profiles and locations; make informed choices.	Providers and care managers access standardized Provider Registries and view clinical performance indicators to make informed decisions re provider selection, provider referrals.	Same as Level 4, on a national scale , where appropriate.
25. Staff do not have time to focus on cultural and linguistic compatibility, member satisfaction, or provider performance.	Cultural and linguistic matches are made.	Cultural and linguistic indicators improve selection of appropriate providers.		
26.	Members are assigned to PCPs to coordinate their care.			
27.		Provider and member satisfaction improves because of speed and accuracy of enrollment process.		