

**Manage Medicaid Population Health: Business Capabilities**

<b>Manage Medicaid Population Health</b>				
<b>Capability Question</b>	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	<b>Level 4 &amp; 5</b>
<b>Business Capability Descriptions</b>				
<b>This Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.</b>				
Is this business process primarily manual or automated?	The process consists primarily of manual, paper based steps. Manual compilation of data is required.	The business process uses a mix of manual and automated steps. Compiled data includes a mix of information gathered manually and automated reports.	The identification of the target population is automated, using a variety of sources. Matching of individuals with programs and materials designed to meet their needs and data compilation are also automated.	
VA As Is	<p><b>2010 MITA:</b> No changes from the 2007 MITA.</p> <p><b>2007 MITA:</b> Most of the programs at DMAS are siloed and they use different trigger events, some of which are automated.</p> <p>Management is primarily manual and conducted by paper or phone. Population Health Management materials are manually prepared and updated.</p>	<p><b>2010 MITA:</b> In addition to phone and paper, state agencies use Websites, Agencies use TV, radio and advertisements to distribute outreach information to targeted members. Text messaging goes to pregnant women and parents.</p> <p><b>2007 MITA:</b> A few of DMAS managed care units are more coordinated and populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socio-economic status, functional</p>		

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		<p>and health needs based on increased standardization of administrative data, and improved data manipulation for decision support.</p> <p>In addition to phone and paper, states use Websites, Agencies use TV, radio and advertisements to distribute outreach information to targeted members.</p>		
VA To Be			<p><b>2010 MITA:</b> All agencies desire to move towards a Level 3.</p> <p><b>2007 MITA:</b> DMAS currently is participating in a transformation grant for the Dept of Aging regarding no wrong door. DMAS would like to expand on the no wrong door participation concept expanding into other populations.</p>	
Does this business process use standards?	Medicaid enterprise uses State specific data standards.	Medicaid enterprise uses its adaptation of national data standards e.g., HIPAA code sets, etc.	MITA standard interfaces and data definitions are used.	
VA As Is	<b>2010 MITA:</b> All agencies continue to pursue national standards for data standards.			

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	This will make all state systems consistent and foster interoperability between systems.			
VA To Be		<b>2010 MITA:</b> All agencies are moving towards a Level 2 and will continue to pursue utilizing national standards for data.		
How does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	The process consists primarily of manual processes (e.g., review of reports, telephone contacts, facsimile, letters) to gather and share information about the status of health in the population and to identify targets for outreach. Collaboration is sporadic and ad hoc.	The process uses proprietary or state systems to document and track cases. Medicaid enterprise accesses a variety of data systems for research, reporting, and to identify members receiving medical care from multiple agencies simultaneously.	Medicaid enterprise collaborates with social services, public health, behavioral health, and community organizations using Service Level Agreements (SLA) and MITA standard interfaces.	
VA As Is	<b>2010 MITA:</b> Most agencies are primarily manual in gathering and sharing information about the status of health in the population.  Several agencies collaborate very consistently and routinely with Early Childhood.			
VA To Be		<b>2010 MITA:</b> Some agencies are using state systems or proprietary		

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		systems to track cases. Continue to move towards a Level 2.		
<b>Business Capability Quality: Timeliness of Process</b>				
How timely is this end-to-end process?	Manual activities negatively impact timeliness	Increased automation improves the timeliness over Level 1.	Use of standard MITA interfaces and analytical tools increases timeliness to identify and assess the needs of special populations. Analysis and research is done in less time than Level 2.	
VA As Is	<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> In addition to the above when fee-for-service enrollees call into DMAS for information, they have to pay for the call since there is no 800 number for them to use.</p>	<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> DMAS does have a website that provides some information to clients. The FAMIS program has its own website for outreach and education. The managed care program areas often refer recipients to the MCO website or to the enrollment broker website for outreach information.</p>		
VA To Be		<b>2010 MITA:</b> Continue to move towards total compliance in Level 2.		
<b>Business Capability Quality: Data Access and Accuracy</b>				
How accurate is the information used in this process?	Manual processes can adversely impact accuracy.	Internal standardization of data, use of HIPAA data exchange standards, and	Use of MITA standardized interfaces and data definitions further improves	

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		increased automation improving accuracy over Level 1.	accuracy to 90% or better.	
VA As Is	<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> This is a struggle for FFS programs but not as much for managed care and FAMIS since selection is automated and service delivery is coordinated.</p>	<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> While automation helps to improve accuracy, it is not a guarantee of access to needed information for all enrollees.</p>		
VA To Be		<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> DMAS would like to improve access to program information for the fee-for-service population.</p>		
How accessible is the information used in this process?	Access to data is controlled manually. Length of time needed to access data is based upon collection methods and type of data selected for review (i.e., claims information, clinical data, vital statistics, etc.).	The process uses automated reports for tracking and calculating improving access over level 1.	Uses standardized MITA interfaces and data definitions improving access over Level 2. The process has immediate access to standardized data from the data source, dependent on networking processing standards in place, and averages no more than 3 seconds.	
VA As Is	<b>2010 MITA:</b> All agencies are operating at a Level 1.			

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	Access to data is a manual process.			
VA To Be		<b>2010 MITA:</b> All agencies are moving towards becoming Level 2 compliant.		
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 operates within State budget constraints. The benefits vary depending upon the types of studies undertaken, the population studied, and the outcome of the research and/or findings.	The process is more cost effective than at Level 1 due to the introduction of data standards and automation. The use of automation reduces and allows additional benefits to be gained by focusing on increased reporting, more effective outreach, more directed outcomes, and automated analysis.	The process demonstrates the improvement value projected by the Medicaid enterprise. The Medicaid enterprise is able to measure the usefulness of the types of studies undertaken, the population studied, and the outcome of the research and/or findings versus the cost of performing the process.	
VA As Is	<b>2010 MITA:</b> No changes from 2007 MITA.  <b>2007 MITA:</b> Managing the Medicaid Population Health for the fee for service population is very labor intensive and requires a large staff.	<b>2010 MITA:</b> No changes from 2007 MITA.  <b>2007 MITA:</b> Targeting enrollees for managed care and FAMIS is automated; most staff focuses on monitoring, auditing and new program development.		
VA To Be	<b>2010 MITA:</b> No changes from 2007 MITA.	<b>2010 MITA:</b> No changes from 2007 MITA.		

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	<b>2007 MITA:</b> DMAS desires more automation for targeting populations served by fee for service.	<b>2007 MITA:</b> DMAS would like automation that would produce a uniformed application or system for targeting and grouping together the fee for service population participating in a variety of manually maintained programs.		
<b>Business Capability Quality: Effort to Perform; Efficiency</b>				
How efficient is this process?	The process is primarily manual.	A mix of manual and automated processes results in increased efficiencies and capability improves over Level1.	Increased automation results in increased efficiencies and capability improves over Level 2.	
VA As Is	<b>2010 MITA:</b> No changes from 2007 MITA.  <b>2007 MITA:</b> DMAS has a large staff working on a variety of population health management programs. Assessments and care plans are manually maintained for most of these programs.	<b>2010 MITA:</b> No changes from 2007 MITA.  <b>2007 MITA:</b> Automated assignment to managed care programs increases operational efficiency. Fee-for-service assignment to waivers, long term and other programs is determined on a case-by-case basis.		
VA To Be		<b>2010 MITA:</b> No changes from 2007 MITA.  <b>2007 MITA:</b> DMAS would		

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		like more timely identification of targeted populations to ensure faster and better service delivery.		
<b>Business Capability Quality: Accuracy; Usefulness of Process Results</b>				
How accurate are the results of this process?	Manual activities may negatively impact accuracy.	Introduction of automation and data standards increase accuracy over Level 1.	The process applies business rules in 99% of occurrences resulting in more uniform decisions, Consistency/accuracy of the process result in 99% confidence level 100% of studies conducted.	
VA As Is	<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> DMAS contracts for call center services for managed care and FAMIS. The fee for service program areas such as long term care, waiver, EPSDT and baby care rely on their staff to answer enrollee calls for service coordination.</p>	<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> The FAMIS program provides limited web resources to its members who can access it.</p>		
VA To Be		<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> DMAS would like to engage in data sharing and interfacing with contracted vendors and sister agencies for distributing needed</p>		

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		program information.		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders (members, providers, tax payers)?	Stakeholder satisfaction is low with few resources dedicated to improvement and few measurements in place.	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 (members, providers, tax payers) satisfaction over Level 2.	
VA As Is	<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> DMAS is meeting its requirements in this area.</p>	<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> Automation of assessment tools and program eligibility has been introduced to long term care and FAMIS programs respectively.</p>		
VA To Be		<p><b>2010 MITA:</b> No changes from 2007 MITA.</p> <p><b>2007 MITA:</b> DMAS would like more fee for service processes to be automated</p>		

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		for better population health management.		