VIRGINIA

Medicaid Information Technology Architecture (MITA)
2010 Updated Transition Report

Prepared by
The Department of Medical Assistance Services
Commonwealth of Virginia

ABSTRACT

This is the biennial report on the status of Virginia's Medicaid Information Technology Architecture (MITA) alignment and results of the 2010 State Self-Assessment (SS-A). The SS-A was based on the MITA Framework Version 2.01 and Behavioral Health MITA Framework Version 2.0. The assessments were conducted during late 2010 through early 2011.

VIRGINIA MITA STATE TRANSITION REPORT

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1. Introduction

The Department of Medical Assistance Services (DMAS) is the single state agency that administers the Medicaid program for the Commonwealth of Virginia (COV). DMAS is one of eleven (11) state agencies within the COV's Health and Human Resources (HHR) Secretariat.

HHR Secretariat agencies are: Department for the Aging; Department for the Deaf and Hard of Hearing; Department of Health; Department of Health Professions; Department of Medical Assistance Services; Department of Behavioral Health and Developmental Services; Department of Rehabilitative Services; Department of Social Services; Department for the Blind and Vision Impaired; Board for People with Disabilities; Virginia Foundation for Healthy Youth; and Office of the Comprehensive Services Act.

DMAS' organization includes an agency director, three deputy directors, and sixteen (16) divisions. The divisions include Internal Audit, Human Resources, Office of Compliance and Security, Maternal and Child Health, Office of Communications and Legislative Affairs, Policy and Research, Long Term Care, Program Operations, Healthcare Services, Program Integrity, Fiscal and Purchases, Information Management, Budget and Contract Management, Provider Reimbursement, Office of Behavioral Health and Substance Abuse, and Appeals. The Medicaid enterprise is distributed across various agencies in HHR. The business arrangements are made via interagency agreements.

Stakeholders in the Medicaid Enterprise include COV state government, Centers for Medicare and Medicaid (CMS), citizens and recipients of services, providers of healthcare and non-healthcare services, and commercial vendors that provide systems and technical/business support for the program.

DMAS has been an active participant in Health Information Technology (HIT) activities in Virginia and maintains a central role not only for funding but as a proactive leader to ensure that the national objectives and realization of the HIT and MITA visions are achieved; Therefore, the 2010 SS-A was conducted with other HHR agencies, which included a Behavioral Health MITA (BH-MITA) SS-A.

The Department of Behavioral Health and Developmental Services (DBHDS) is also one of the eleven (11) state agencies within the COV's HHR Secretariat. The system is comprised of sixteen (16) state facilities and forty (40) locally run community services boards (CSBs); all of which serve as DMAS enrolled providers. The CSBs and facilities serve children and adults who have or who are at risk for mental illness, serious emotional disturbance, intellectual disabilities, or substance use disorders.

One of the goals from DBHDS' current strategic plan directs the agency to assure that services, system infrastructure, and technology efficiently and appropriately meet the needs of individuals receiving publicly funded mental health (MH), mental retardation (MR), and substance abuse (SA) services and supports. The BH-MITA SSA is the first step towards achieving that goal. DMAS and DBHDS are aligned in developing technology that supports interoperability,

electronic health records/personal health records (EHRs/PHRs), and health information exchanges (HIEs).

The following DBHDS facilities are enrolled DMAS providers:

Facilities	
Catawba Hospital	Western State Hospital
Central State Hospital	Central Virginia Training Center
Commonwealth Center For Children & Adolescents	Northern Virginia Training Center
Eastern State Hospital	Southeastern Virginia Training Center
Northern Virginia Mental Health Institute	Southside Virginia Training Center
Piedmont Geriatric Hospital	Southwestern Virginia Training Center
Southern Virginia Mental Health Institute	Virginia Center for Behavioral Rehabilitation
Southwestern Virginia Mental Health Institute	Hiram W. Davis Medical Center

The following DBHDS CSBs are enrolled DMAS providers:

Community Services Board	
Alexandria Community Services Board	Highlands Community Services
Alleghany Highlands Community Services Board	Loudoun County Community Services Board
Arlington County Community Services Board	Middle Peninsula-Northern Neck Community Services Board
Blue Ridge Behavioral Healthcare	Mount Rogers Community Mental Health and Mental Retardation Services Board
Central Virginia Community Services	New River Valley Community Services
Chesapeake Community Services Board	Norfolk Community Services Board
Chesterfield Community Services Board	Northwestern Community Services
Colonial Behavioral Health	Piedmont Community Services
Crossroads Community Services Board	Planning District One Mental Health and Mental Retardation Services Board
Cumberland Mountain Community Services Board	Portsmouth Department of Behavioral Healthcare Services
Danville-Pittsylvania Community Services	Prince William County Community Services Board
Dickenson County Behavioral Health Services	Rappahannock Area Community Services Board
District 19 Community Services Board	Rappahannock-Rapidan Community Services Board
Eastern Shore Community Services Board	Region Ten Community Services Board
Fairfax-Falls Church Community Services Board	Richmond Behavioral Health Authority
Goochland-Powhatan Community Services	Rockbridge Area Community Services
Hampton-Newport News Community Services Board	Southside Community Services Board
Hanover County Community Services Board	Valley Community Services Board
Harrisonburg/Rockingham Community Services Board	Virginia Beach Community Services Board

Community Services Board	
Henrico Area Mental Health & Developmental Services	Western Tidewater Community Services Board

DBHDS has day-to-day oversight and operational responsibility for the ID Waiver (formerly known as the MR Waiver) and the Day Support Waiver; However, DMAS maintains the overall authority related to these waivers. It was through this relationship that DMAS was able to conduct BH MITA SS-A with the full support and participation of DBHDS.

1.1 Scope of the SS-A

DMAS' scope includes reviewing the current strategic goals and objectives, revising the 2007 SS-A business processes and capabilities baseline against the current MITA framework model, and targeting capabilities to transform the Virginia Medicaid Enterprise to be consistent with MITA standards and principles over time.

Converging efforts played a role in shaping the scope of the 2010 SSA. Requirements from the American Recovery and Reinvestment Act (ARRA), the Patient Protection and Affordable Care Act (ACA) and the Medicaid expansion targeted for 2014 emphasized the need to develop patient self-directed decision making systems. In addition, the MITA framework has not been updated since the 2007 SS-A effort. Therefore the 2010 SS-A focused on the MITA business areas that needed to be aligned with Federal efforts initiated after the 2007 SS-A: Member Management and Care Management Business Processes that are critical support areas for the new federal initiatives under ARRA and ACA.

The scope of the first SS-A did not include other state agencies participation as the 2007 effort was viewed primarily as a learning experience; However, the 2010 SS-A effort did include a much broader participation from other state agency stakeholders. The agencies participating in the Member Management and Care Management SS-A included the Department of Social Services (DSS), Virginia Department of Health (VDH), Division of Consolidated Laboratories and, the Virginia Department for the Aging (VDA). A number of State Agencies from multiple Secretariats as well as the HIT Advisory Committee (HITSAC) participated in the MITA technical capabilities assessment: HHR Agency Chief Information Officers/IT Directors; Virginia Information Technology Agency; Department of Motor Vehicles; Division of Consolidated Laboratories; Department of Corrections; and HITSAC members.

Staff from the state facilities, CSBs and central office participated in the BH MITA SS-A. See Attachment A for details.

1.2 Summary of Current Level of Maturity

The Virginia SS-A has established a current level of maturity for each business area and has documented the levels in a Business Capability Matrix (BCM). For each Business Process a boundary of current capability has been identified as measured against the five levels of the MITA Maturity Model.

The following is a summary of the business areas and the current level of maturity for each area.

Medicaid:

- **Member Management –** The current Member Management functions are identified as Level 1. Incremental progress has been made since 2007 that continue to raising the maturity level of some processes. These projects include: the expansion of No Wrong Door, improvements to the MMIS as part of the takeover project, development of a Customer/Citizen-Centric Portal (a DSS project currently in execution). However, there were not significant overall improvements as alignment of strategic direction for HHR Agencies was lacking. Further, a hub based architecture (SOA) and supporting technical infrastructure does not exist in Virginia.
- **Care Management –** The functions for Care Management have been identified as Level 1. Incremental progress was made that nominally raised the maturity level. However, like Member Management, there were not significant overall improvements as alignment of strategic direction for HHR Agencies was lacking as well as a hub based architecture (SOA) and supporting technical infrastructure does not exist in Virginia.
- An Executive Support System is under development and that will eventually house the EMR generated Quality of Care reports and improve the reporting condition.

Behavioral Health:

- **Provider/Contractor Management** – DMAS has identified the functions in this category as Level 1 with higher levels of functionality existing among some of the CSBs and central office. For this business process, a lack of national standards acted as a barrier to improve beyond levels 1 and 2. The agency claims a level 3 under Cross Coordination. DBHDS does not have administrative control over providers therefore the following business processes could not be assessed: *Perform Potential Contractor Outreach, Inquire Contractor Information, Support Contractor Grievance and Appeal, Manage Contractor Information* and, *Manage Contractor Communication.*
- **Client Management –** DMAS has identified the functions in this category as Level 1 with higher levels of functionality existing among some of the CSBs and facilities. For this business process, there is a higher level of functionality and consistency between the CSBs in the areas of accessing client-level data and interoperability.
- **Operations Management –** DBHDS does not pay providers nor manage any payment-related processes relevant to this business area. Only a few business processes from this area could be assessed: *Authorize Service/Level of Service, Collect Client Fees, Develop Sliding Scale, Prepare Client Invoice* and, *Authorize Referral.* DMAS has identified the functions in this category as Level 2.

- **Program Management –** DMAS has identified that most functions in this category are at a level 2. Higher levels of functionality are realized in the *Manage State Funds* and *Manage Federal Funds* business areas.
- **Business Relationship Management –** DMAS has determined that the functions in this category cross levels 1 and 2. DBHDS does not have a primary role in administering or managing provider relationships.
- **Accountability Management –** Functions in this category cross levels 1, 2 and 3 but tend be more consistent at level 3 for cross coordination and interoperability within the DBHDS organization.
- **Care Management –** Functions in this business area consistently meets the requirements of level 2. In the area of *Prevention*, the agency notes that prevention is usually conducted one-on-one, on a case-by-case basis so very little automation is required.

1.4 Summary of Future Capability of Improvement

DMAS has reviewed the MITA Maturity Model in light of ARRA and ACA requirements and has determined capability targets for the MITA Business Areas and the Behavioral Health Business Areas. In summary, the following are key aspects affecting future capabilities:

1. MITA must be the central strategy to drive the Medicaid Enterprise direction in Virginia.
2. DMAS must be an active agent of, and promoter for change within Virginia. To ensure this occurs, DMAS seeks to establish an HHR HIT/MITA Program Office to fund and monitor projects of importance to Medicaid.
3. Virginia must take an enterprise view (multi-Secretariat) for SOA technology services to maximize usage and minimize costs.
4. A MITA-complaint technical architecture is necessary in Virginia. This SOA environment must be available to all stakeholder groups on a cost shared basis. The environment must include commercially available Enterprise Service Bus, workflow engine, business rules engine, master data management products. It will leverage existing assets, projects, and efforts in Virginia.
5. Leveraging the Virginia HIT Advisory Committee (HITSAC) to harmonize internal/national standards for services/interfaces to include implementation guides in order to enable interoperability.
6. Leverage the DSS enterprise efforts (customer/citizen-centric portal)

In order to meet ARRA and ACA requirements, future capability improvements in the near term (1-2 years) are organized into Phase I. Mid-term capability improvements are organized into Phase II. (2-5 years).

Medicaid:

- Member Management – The current Member Management functions are targeting a capability of Level 3 and beyond with development and implementation of a citizen-centric portal (under development by DSS). The central phase I theme is to “bolt”

existing technology onto SOA technology using National Standards for supporting enterprise-wide interoperability. For member management, this provides automation to help address Medicaid Expansion by introducing a MITA Technical Architecture Standard eligibility system that can automate routine time-consuming activities. DSS enterprise efforts are using the Michigan government owned Integrated Social Services Delivery system (portal and child support system). Phase II efforts will leverage the remaining components in the Michigan MITA technical Architecture Standard system to replace the current eligibility systems with one that can meets the CMS seven conditions and standards for enhanced eligibility system funding.

PHASE I MEMBER MANAGEMENT TIMELINE	
Development Window	10/15/2011- 12/29/2012
User Acceptance Test Starts	1/1/2013
Project in Production	7/1/2013
Medicaid Expansion	1/1/2014

Phase I will not address the lack of case management for all Medicaid populations nor will it replace all the current manual processes. Phase I should be viewed as establishing a MITA Technical Architecture compliant technical environment; supporting the DSS customer portal project (based on the Michigan Integrated Social Services Delivery System); providing improved automated verification services, and starting the migration of the Medicaid eligibility determination rules into a COTS rules engine.

PHASE II MEMBER MANAGEMENT TIMELINE	
Project window	10/15/2012- 1/1/2015

Phase II will address case management as well as gap analysis of existing legacy eligibility systems; it is likely to be based on the Michigan system that DSS has selected for some components of their social services enterprise. The goal of this effort is to replace and retire several legacy eligibility systems used to support multiple programs.

- **Care Management** – The current Care Management functions are targeting a level 3 and beyond with development and implementation of enterprise applications and architecture to facilitate access to Care Management services via the COV Gateway and COV HIE.

  The State Medicaid HIT Plan (SMHP) Goal 4 is to leverage MITA in order to accomplish the following objectives:

  - Objective 4.1: Establish the COV State Government Gateway that allows COV-HIE access to State government assets such as immunization registry, syndromic surveillance, and state labs.
  - Objective 4.2: From the updated MITA SS-A transition plan, initiate projects to develop the required SOA-based services needed by the COV-HIE Care Management business area.

- Objective 4.3: For the SOA services that are identified, establish harmonized standards.

CARE MANAGEMENT TIMELINE	
Project Execution Phase	9/10/2011 – 8/3/2012
Phase 1 – HIE Build	8/1/2011 – 2/1/2012
Phase 2 – Pilot Phase	2/1/2012 – 8/3/2012
Medicaid Expansion	1/1/2014

Behavioral Health:

- The primary near-term objective is to obtain an EMR and be able to exchange health information via the HIE for all facilities and CSBs. This will be a challenge as these facilities and professionals do not qualify under the provider incentive program. However, there is no choice since the Medicare rates will drop in 2015 if a certified EMR is not being meaningfully used by the BH facilities and CSBs.

BH EMR TIMELINE	
Project Execution Phase	2011 – 2014

1.5 Major Conclusions

DMAS' Strategic Plan addresses areas for improvement. There are several factors that will impact Virginia Medicaid in the future including: (i) Federal initiatives under ARRA and ACA (ii) the aging population, especially those age 85 and older; (iii) an increase in the number of persons with disabilities seeking services; and (iv) continued growth in overall program enrollees and costs.

The following are among the top priorities for DMAS in the future:

- Continue to involve COV stakeholders in the alignment of efforts with MITA;
- Continue to involve impacted agencies with MITA planning and direction;
- Respond to State and national Medicaid reform issues;
- Proceed with integrating acute and long-term care services;
- Expand managed care enrollment to include new geographic areas and populations;
- Increase retention efforts to keep eligible children enrolled in Medicaid and FAMIS;
- Enhance the Department's capabilities and activities in preventing, identifying, and eliminating fraud and abuse;
- Improve the effectiveness of waiver programs serving the elderly, and persons with mental retardation or other disabilities, and developing Program for All Inclusive Care for the Elderly (PACE) sites;
- Monitor the new dental program and make any needed adjustments to improve access to care;

- Increase the use of electronic systems to improve internal processes and administrative efficiencies; and
- Improve Small Business Contracting and Purchasing.

In conclusion, there are several tactics identified by Virginia Medicaid in order to achieve improvements:

- Continue to seize opportunities for leveraging existing COV groups, committees, and organizations for MITA alignment and coordination efforts going forward. Significant progress has been made on this since the 2007 SS-A;
- Continue to seize opportunities to leverage COV initiatives for better services to citizens through programs such as "No Wrong Door", PACE, and "Money Follows the Person;" and Federal initiative under ARRA and ACA.
- Move to a more modular "Best of Breed" Medicaid Enterprise Architecture.

By incorporating these strategies into the Virginia Medicaid Enterprise "To-Be" model, the intention is for Virginia to transform some capabilities to Level 3 in the short run (Care and Member Management), and higher levels in the future. Transformation of functions to higher levels will be a result of alignment of the Agency's strategic plan with evolving technical and business solutions.

2. State Vision and Objectives

As noted, in the State Medicaid HIT Plan (SMHP), MITA is the central strategy being used by Virginia to achieve its Enterprise vision and ARRA and ACA are serving as a catalyst for action. The 2010 SS-A involved many stakeholders in Virginia and has served to align business and technical efforts. Updates to Agency strategic plans are planned by HHR agencies to formalize alignment with MITA and its Enterprise Architecture (technical architecture standard). The SOA technical environment will be a cost-shared environment that will be available to federal, state, local governments, HIE, NGOs, and commercial interests.

Figure 1 depicts the to-be vision for the Commonwealth. It is based on the Medicaid IT Architecture (MITA) Technical Architecture Standard. The standard requires a Service Oriented Architecture (SOA) using standard compliant services/information for interoperability. The SOA Commercial off the Shelf (COTS) products are readily available. The major components include an enterprise service bus (ESB) for enterprise connectivity; a work flow engine to orchestrate services (manual/automated) and support performance monitoring; and a business rules engine for storing rules as data. In addition, there is a master data management (MDM) COTS product added that contains master person/patient index (MPI) as well as a master business/provider index. Existing data warehouses and document management systems may also be connected.

Two models of customer/citizen access will support Health and Human Resources Secretariat Agencies. One is an assisted service model and the other is a self-service model per the MITA Concept of Operations (new).

The initial objectives (phase I) are to connect existing legacy systems to the SOA technology using national/international standards as identified by HIT Standards Advisory Committee

(HITSAC) and approved by the VITA CIO and Secretary of Technology. This allows interoperability on the enterprise. Long term objectives are to leverage the technology to replace legacy systems as business needs dictate.

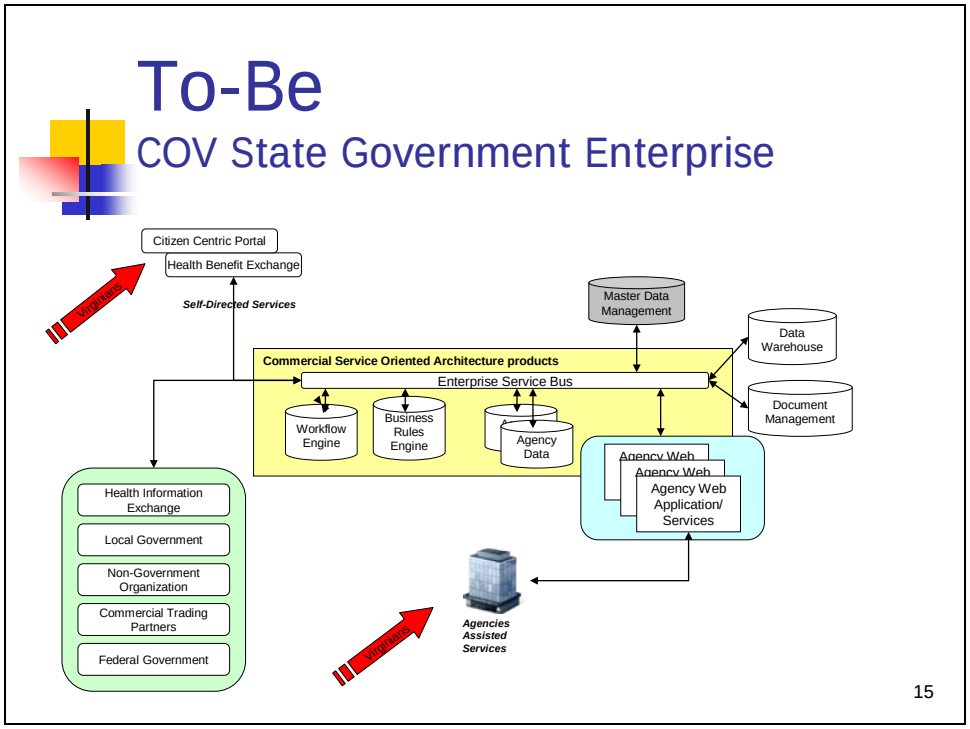

Figure 1 To-Be Vision

2.1 *Summary of 5, 10-year Vision*

Virginia shares the MITA vision (to include HIT) and recognizes that it is compatible with the COV vision. Virginia also recognizes that transformation on the scale of MITA will take close cooperation between federal, state and local governments, standards groups, industry, and trading partners. Further, DMAS realizes a sustained effort over time on MITA alignment within Virginia state and local government agencies is needed for direct alignment of vision, objectives, strategy, planning, and implementation efforts. As part of this recognition, the existing DMAS HIT/MITA Program office has been expanded and now reports to the Secretary of HHR to better coordinate improvements for the Medicaid enterprise.

The five-year goal is to:

(1) To align state and local government vision, strategy, and planning to focus on federal initiatives (HIE, HBE, and Medicaid eligibility systems). These efforts would be coupled with additions to the enterprise technical architecture of SOA, Master Data Management, and expanding Data Warehouse (DW) technologies as well as supporting interoperability for the COV-HIE to the MDM, state labs, and health department systems needed for meaningful use.

(2) To scale existing DSS Social Service Enterprise planning for an HHR wide enterprise to address the replacement of current eligibility systems in order to meet Federal requirements under ACA. This will result in all Medicaid eligibility rules to be stored in one COTS rules engine and one data base of eligibility information. The MMIS recipient subsystem will be retired as will a number of DSS systems and platforms and the MMIS claims engine will be tied into the enterprise via the ESB to access the necessary eligibility information.

The ten plus year vision is for Virginia to continue to maintain a close alignment with MITA (includes HIT) efforts and to continue to use multi-agency process improvement efforts for MITA as dictated by the BCM. The current MMIS itself would continue to be encapsulated by MITA compliant SOA interfaces. The provider subsystem will be looked at from an enterprise perspective and replaced by a best-in breed self-directed services solution as well as expanding the Medicaid data warehouse reporting capability to replace MARS and SURS. At some point the remaining components (Claims and Financial subsystems) will be targeted for replacement by an enterprise solution.

2.2 *Modularity Standard*[i]

Modularity condition requires the use of a modular, flexible approach to systems development, including the use of open interfaces and the separation of business rules from core programming as well as the availability of business rules in both human and machine readable formats. In establishing a Virginia SOA environment, a COTS workflow and rules engine is key part of that vision. These tools allow the separation of work processes (workflow) and business rules from hard-coded programming. It will also result in capabilities to export/import both workflow and business rules.

These COTS tools will be leveraged as the legacy eligibility systems are replaced.

2.3 *MITA Condition*

DMAS reviews the MITA Condition every two years to determine when to conduct an SS-A. In cases where the MITA framework has been updated or significant internal/external events have arisen, an SS-A is appropriate. For CY2009 there was not a pressing need apparent for performing an SS-A update. However, with the advent of ARRA and ACA, a targeted update was necessary. Two MITA business areas were selected for update: Care and Member Management business areas. In addition, BH-MITA SS-A was conducted for the first time.

Implementation of Care Management and Member Management business area projects will increase the maturity level in these areas to a level 3. Additionally, this leads to replacement of eligibility systems, retirement of a number of legacy eligibility systems and a significant move towards citizen self-directed services capabilities.

2.4 *Industry Standards Conditions*

Compliance with HIPPA and the use of HL7 standards are inherent to the MITA business processes and are being complied with where applicable. Further, interoperability means more than compliance with the standard; it also means use of standard implementation guides/specifications.

Virginia created an organization called HIT Standards Advisory Committee (HITSAC) to advise the Commonwealth on HIT standards. This body is responsible for harmonizing the plethora of external standards and identifying those that the Commonwealth should be using. It should be noted, that the Commonwealth will not be establishing its own standards but utilizing existing national standards.

The HITSAC charter was expanded in 2011 to include standards used within the HHR Secretariat.

HITSAC is developing a web based, health vocabulary and health interoperability data standards repository to designate medical terminology, medical procedures, measurements and messaging and service standards in their information technology systems and data exchanges. Through this online tool, government bodies and commercial trading partners will be able to find the implementation guides/specifications needed for establishing interoperability with the Commonwealth.

2.5 *Leverage Condition*

The COV is planning to leverage MITA as part of a broader effort to reorient essential state services to a citizen-centric paradigm to prepare for the future; a future that includes a Health Information Exchange and support for a Health Benefit Exchange. Virginia will leverage existing SOA based efforts and technology in order to establish a Commonwealth Enterprise Architecture that can support the Medicaid Enterprise to include master data management. Further, Department of Social Services enterprise projects will be leveraged to start to transform targeted MITA Care and Member business areas toward MITA's concept of operation for citizen-centric services. These projects will address replacement of the current multiple eligibility systems by a single integrated MITA compliant social services delivery system. Additionally, VITA DHHS approved cost allocation plan allows use of the SOA environment on a cost-sharing basis as allowed by Federal and State policy. Finally, HHS will leverage the HITSAC standards harmonization effort in order to identify standards and implementation guides for Commonwealth enterprise services/interfaces.

2.6 *Business Results Condition*

DMAS plans as part of the HHR enterprise effort to have a single highly automated eligibility system that supports both self-directed service option (citizen-centric portal) as well as an assisted service option using the replacement. The existing rules-based MMIS claims engine would be connected to the eligibility system via the Commonwealth's Enterprise Service Bus using HITSAC harmonized standards. The MMIS claims engine, once the multiple legacy eligibility systems are retired, can be run during normal business hours to provide near-real time processing of all claims.

DSS is leveraging the government owned Michigan system developed by Deloitte by using it for their child support system as well as for the customer/citizen-centric portal. As part of a phase II effort, the vision for supporting an expanded Medicaid population as well as the benefits exchange can be best accomplished by leveraging the complete integrated Michigan system solution. Accordingly, a gap analysis will be done between the Michigan system and the legacy

eligibility systems (three primary systems) with the intention of replacing all of the legacy systems with one integrated MITA compliant eligibility system solution. There will be a great deal of operational efficiencies gained that will significantly enhance customer service.

With the use of the Michigan system, work flow metrics as measured by the technology will be possible. This will lead to reporting on performance and make possible establishing Service Level Agreements (SLAs). None of this is possible with Virginia's current legacy systems.

2.7 *Reporting Condition*

A Medicaid Executive Support System (ESS) based on data warehouse technology is in development and due to be completed summer 2011. Feeds to the data warehouse come from a variety of legacy systems. Electronic Medical Records (EMR) generated Quality of Care Reporting that providers are required to report on populations will be loaded into this repository. Further, this repository will be the interchange mechanism with CMS. Over time, MMIS backend reporting subsystem functionality packages will be added to the ESS to retire the legacy backend reporting subsystems using a best-in-breed solution.

2.8 *Interoperability Condition*

The Commonwealth's MITA compliant technical architecture is the foundation for the MITA initiatives, specifically the Care Management projects that will establish interoperability with Federal systems; COV-HIE; future health befit exchange; DSS integrated eligibility system (including the customer/citizen centric portal supporting self-directed services); MMIS; state and local government agencies; non-government organizations; community based partnerships; and trading partners. The interoperability will be based on national/international standards that are harmonized by HITSAC (organization responsible for keeping up with standard setting organizations as well as federal initiatives).

3. Current Organization and Systems

Virginia organizations and systems details are documented in Appendix E, Virginia Medicaid Enterprise Architecture.

3.1 *Summary of State Enterprise Organization*

Virginia Enterprise Organization is through the Virginia Information Technology Agency (VITA).

VITA is headed by the Chief Information Officer (CIO) who reports to the Secretary of Technology. VITA is primarily responsible for the Enterprise Architecture policies, standards, and technology. VITA owns and supports the technology located at DMAS and will host the SOA and MDM environments and offer that as a service to all Agencies, local government bodies, NGOs, and commercial interests according to policy. Costs and charge backs will be based on VITA's DHHS approved cost allocation plan (CAP).

3.2 *Outsourcing*

VITA has outsourced platforms and technical infrastructure to Northrop Grumman (NG). Technical infrastructure modernization continues at a brisk pace. Details on the VITA/NG partnership are available on the VITA website.

3.3 *Locations*

There are two new state-of-the-art NG data centers used to support Virginia processing and technical needs as well as supporting other NG clients. The primary data center is located in Central Virginia with a hot backup site located in southwest Virginia.

The current Fiscal Agent has offices in the Richmond area. The data centers used to support Virginia MMIS are located in Tampa FL (mainframe) and in Tarrytown NY (servers).

4. State's Enterprise Architecture

Virginia has an established enterprise architecture that is documented in Attachment E, Enterprise Architecture reference. It should be noted, that Virginia's Enterprise Architecture was adapted for State needs from an existing Federal model. As such, Virginia is already closely aligned with Federal Enterprise Architecture efforts.

5. Approach to the Self-Assessment

5.1 *Organization and Staffing Project*

The MITA SS-A project was coordinated and led by the DMAS HIT/MITA Program Office. There was a dedicated project manager and a core team of HIT/MITA Systems Analysts that defined the project scope and activities and prepared assessment materials for the staff who were requested to participate in the SS-A. The core team used the process and materials from the 2007 SS-A effort.

The HIT/MITA Systems Analysts were assigned to each business process and given the responsibility for ensuring the SS-A for the assigned processes was performed in accordance with the defined approach.

The 2010 business team lists were developed for each of the business processes targeted for the SS-A effort. The DMAS Directors were presented with the proposed assignments and asked to add or delete staff members in order to finalize the composition of the teams. Once the teams for each business process were finalized, the HIT/MITA Analyst assigned to each team scheduled team meetings to begin the state self-assessment. See Attachment A for details.

5.2 *Duration and Scope*

A schedule was prepared for conducting the self-assessment. The MITA SS-A efforts to update selected 2007 documents went quickly. The BH-MITA took much longer as only one

session per week was conducted in order to minimize impact on BH staff and maximize participation. See Attachment A for details.

The scope of the self-assessment included one or more meetings to review and discuss the Business Process Model (BPM) and Business Capability Model (BCM) for each business process that pertained to DMAS.

The teams used the BPM and BCM provided in the MITA Framework Version 2.01 and the BH-MITA Framework Version 2.0 as a basis for the sessions.

A column was added to the BPM and labeled "VA As-Is Details." Within the column the 2007 responses were transferred to the new BCM under the heading "2007 MITA." Within the same column an additional heading, "2010 MITA" was added to capture the 2010 "as is." The Business Process Model was read and discussed, and then the Virginia MMIS "as-is" column was used to document any differences to the "Details." A difference was documented when a step was not performed at all, performed in a substantially different manner, or if additional steps were performed. Differences in how the process was performed for the Virginia MMIS were documented as they were identified by the business team in the meeting.

Two rows were added to the BCM under each capability. One was used to document the Virginia MMIS "as-is" and the second was used to document the Virginia MMIS "to-be." The 2007 responses were transferred to the new BCM and labeled, "2007 MITA" and the new responses for "as-is" and "to-be" were captured under the label, "2010 MITA." The information in the existing model was used as the basis to determine what we did and wanted to do. The added rows were completed in the meetings based on the input and discussion of the business teams.

The BH-MITA Business Process Model (BPM) provided elements of both a MITA BPM and a Business Capability Matrix (BCM). It was combined with the Self-Assessment Checklist to add quality markers and measures for the assessment. After each quality marker, two rows were added to captures the "VA As-Is 2010" and the "VA To-Be 2010;" Issues and Resolutions

The biggest issue in performing the Virginia State Self-Assessment was that the framework had not been updated; there was no formal release of version 2.0a. DMAS learned through the Business Architectural Review Board (BARB) that version 2.01 of the BCMs and BPMs were available from the Clemson University repository (http://mita.clemson.edu). DMAS has documented some detailed issues and suggestions about the BPMs and BCMs; refer to Attachment A for details.

5.3 *Recommendation for Improving the SS-A Process*

None.

6. Mapping of State Business Areas to MITA

6.1 *Table Showing Mapping*

None required.

6.2 *Notes on Exceptions, Differences*

There are no exceptions to or differences between the MITA and State business areas.

6.3 *Include Other Programs, Agencies if Applicable*

HHR agencies that participate in Medicaid participated in the MITA Care and Member Management business area processes. The technical capabilities session also included representation from other Secretariat agencies (DMV, Corrections). It also included HITSAC members.

7. Mapping of State Business Processes to MITA

7.1 *Table Showing Mapping to MITA Business Processes*

None required.

7.2 Notes on Exceptions, Additions, Differences and Non-applicable Business Processes

8. Results of Assessment of Current Business Capabilities

None are applicable.

8.1 *Table Showing Assignment of Level of Business Capabilities per Business Process*

The assignment of level of business capabilities per business process is captured in Attachment A, "As-is, To-be" summary.

8.2 Notes on Exceptions, Differences

None are applicable.

8.3 Summary of Environment

The current environment of the Virginia Medicaid Enterprise is evolving from legacy solutions to more modular solutions. The COV is planning to leverage MITA as part of a broader effort to reorient essential state services to a citizen-centric paradigm to support ARRA and ACA requirements. The effort began with an HHR secretariat-wide MITA SS-A to align business strategy and direction. Based on the resulting updates to the MITA Transition plan, additional projects will start to transform targeted MITA business areas toward MITA's concept of operation for citizen-centric services. Other State programs will seek support from their applicable Federal partners to follow the MITA initiatives and begin their own transformation to SOA, standards, and a citizen-centric paradigm.

For Medicaid, these efforts target avoiding cost increases in administrative and operational support that would be necessary for an expansion of Medicaid under the Health Reform Act; However, for the COV-HIE, it will establish broad standards-based capabilities to coordinate and orchestrate future patient services as well as share and exchange health-related information between provider networks and the Commonwealth that is far beyond current capabilities.

The key to the business and technical transformation is standards. The SOA technology components are based on industry standards. Information standards used on the COV SOA are paramount; accordingly, the HITSAC charter will be expanded to harmonize industry standards for the HHR agencies just as it did for the HIE. This harmonization will ensure future capabilities to exchange information between the COV-HIE Federal and State government systems.

9. Results of Assessment of Current Technical Capabilities

Results of current and targeted technical capabilities are documented in the Attachment E, MITA Technical Capabilities Matrix.

10. Results of Determination of Enhancement of Business Capability

Not applicable.

11. Results of Determination of Technical Capability Enhancements

Not applicable.

12. Transition

Transformation on the scale of MITA takes close cooperation between Federal, State and local governments, standards groups, industry, and trading partners. This requires a sustained effort by DMAS to facilitate alignment and coordination efforts within state and local governments. Accordingly, DMAS has designated a MITA program manager to begin the alignment and coordination processes in Virginia. A great deal has been accomplished since the 2007 SS-A in this area to create awareness of, and participation in MITA and its processes by state and local government agencies. The national health care efforts and Federal initiatives have been a catalyst that is resulting in a formal alignment of vision, strategy, and coordination for MITA in the COV.

The transition strategy is documented in Attachment E. It consists of the following:

- Repeat State Self Assessment (SS-A) every two years to align/realign Virginia's effort with MITA direction and industry standards;
- Leverage Virginia's existing Enterprise Architecture; business, information, and technical architectures; and
- Leverage Virginia's existing working groups, steering committees, councils, industry and user groups to educate, convey information, collaborate, and coordinate efforts.

The technical transition strategy is documented in Attachment E. It consists of the following steps:

- Position technology for MITA Alignment;
- Define MITA standard interface SOA adapters – external to MMIS;
- Use MITA standard interface SOA adapters – internal to MMIS; and
- As business needs dictate, replace MMIS subsystems/components.

The transition plan is documented in Attachment E. It is included in the following figure.

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[i] CMS. Enhanced Funding Requirements: Seven Conditions and Standards. Medicaid IT Supplement (MITS-11-01-v1.0) Version 1, April 2011.

Transition to MEA

Note: Does not imply any specific scheduling, priorities, or dependencies

Step	CY2007	CY2008	CY2009	CY2010	CY2011	CY2012	CY2013	CY2014	CY2015
Step 1: Position Technology for MITA Alignment	SS-A	Planning* (APD) , procurement, migration							
Step 2: Define MITA standard interface SOA adaptors – External to MMIS			SS-A	Planning (APD) ,initiate projects					
Step 3: Use MITA standard interface SOA adapters - Internal to MMIS					SS-A	Planning (APD) ,initiate projects			
Step 4: As business needs dictate, replace MMIS subsystem/components							SS-A	Routine MITA alignment cycles	SS-A**

MEA Operational

Notes:
*Planning involves detailed planning for the MEA SOA (governance, SOA technology, contracting/SLA) with VEAP, VITA, and other key Commonwealth stakeholders.
**SS-A alignment process repeated every two years to remain in alignment with MITA and CMS. The SS-A will drive what new actions/projects need to be defined and may alter this timeline.

Assumptions:
1. VEAP and VITA are active partners in MITA activities.
2. Virginia strategic planning aligns with MITA at all levels (Governor, Secretariat, and Agencies).
3. MITA information and service standards for adapters/interfaces as well as workflows are defined. It is likely that these will be emerging standards and DMAS should plan for an active participation in the standards working groups by technical resources (may not be DMAS staff) assigned to the MEA.
4. SS-A identified business process improvement efforts/projects are conducted in parallel with the MEA transition. The MEA will be an enabler for a number of transformational business process improvement efforts/projects. Close coordination in this area will be necessary.
5. External factors do not impact timeline.
6. Future DMAS SS-A efforts or changes to MITA framework by CMS or industry will not impact timeline.

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The Virginia MITA Transition Report includes the following appendices:

Attachment A. Transition Report Supporting Details

This attachment is a separate document and contains information that is directly referenced in this report. For ease of reference, Attachment A includes the following:

SS-A Team List
SS-A Team Member to Process Mapping
SS-A Calendar/Schedule
Issues and Suggestions
Sample BH-MITA BPM/BCM Checklist

Attachment B. Member Management BPM/BCM Details

This attachment is a separate document and contains the following:

BPMs/BCMs used for the SS-A
Member Management Summary

Attachment C. Care Management BPM/BCM Details

This attachment is a separate document and contains the following:

BPMs/BCMs used for the SS-A
Care Management Summary

Attachment D. Behavioral Health BPM/BCM Details

This attachment is a separate document and contains the BPMs/BCMs Checklist and Summary documents for the following business areas:

Provider/Contractor Management
  Provider/Contractor Management Summary
Client Management
  Client Management Summary
Operations Management
  Operations Management Summary
Program Management
  Program Management Summary
Business Relationship Management
  Business Relationship Management Summary
Accountability Management
  Accountability Management Summary
Care Management
  Care Management Summary

Attachment E. Medicaid Enterprise Architecture (MEA)

This Attachment is a separate document and contains the Virginia Medicaid Enterprise Architecture (MEA) and details the following:

MITA Strategy
Current Conceptual Architecture
Steps to MEA
Transition to MEA

ATTACHMENT A

ATTACHMENT A

SSA Teams for Care Management, Member Management and, Behavioral Health

Department of Medical Assistance Services Team (DMAS)

Name	Team
Beth Ferrara	All
Brian Campbell	Member & Care Management
Carrie McDermott	All
Cindy Olson	Member & Care Management
David Mix	All
Jeryl Childs	All
Karen Packer	Member & Care Management
Karen Rowson	All
Mahalia Arnold	Member & Care Management
Mary Mitchell	Member & Care Management
Melissa Fritzman	Member & Care Management
Patricia Taylor	Member & Care Management
Samuel Metallo	Member & Care Management
Susan Offie	Member & Care Management
William O'Bier	Behavioral Health

Department of Social Services Team (DSS)

Name	Team
Donna Deboard	Member & Care Management
Jeanne Rock	Member & Care Management
Judith Sandler	Member & Care Management
Katherine Peters	Member & Care Management
Margaret Roach	Member & Care Management
Marie Barnes	Member & Care Management
Nancy Smith	Member & Care Management
Roxana Worth	Member & Care Management
Sandra Goff	Member & Care Management
Wanda Hoerman	Member & Care Management

Virginia Department on Aging Team (VDA)

Kathy Miller	Member & Care Management

ATTACHMENT A

SSA Teams for Care Management, Member Management and, Behavioral Health

Virginia Department of Health Team (VDH)

Catherine Bodkin	Member & Care Management
Jim Martin	Member & Care Management
Kim Barnes	Member & Care Management
Lisa McCullen	Member & Care Management
Nancy VanVoorhis	Member & Care Management
Robin Buskey	Member & Care Management

ATTACHMENT A

SSA Teams for Care Management, Member Management and, Behavioral Health

SSA Team for Behavioral Health Client Management

Name
Amanda Goza
Don Obenshain
Florence Wells
Marion Greenfield
Michael Shank
Michelle Porter
Peggy Vaughan
Roberta Carey
Robin Crews
Sterling Deal
Teresa Pigue
Theresa Anderson
Thomas Davies
Wanda Whittaker

SSA Team for Behavioral Health Operations Management

Name
Shaquwanda Baker
Debbie Bender
Pumphrey Cathy
Amanda J Currin
Olivia Garland
Paul Gilding
John Jackson
David Mawyer
Don Obenshain
David Ray
Florence Wells
Brian Whitesell

ATTACHMENT A

SSA Teams for Care Management, Member Management and, Behavioral Health

SSA Team for Behavioral Health Program Management

Name
Sharon Becker
Robin Crews
Charline Davidson
Mark Diorio
Wanda Fitzgerald
Ken Gunn
Sanford Hostetter
Jim Martinez
Vicki Montgomery
Priscilla Scherger
Joy Yeh

SSA Team for Behavioral Health Provider/Contractor Management

Name
Cathy Pumphrey
Cecil Hardin
Jon Chapman
Ron Harris
John Jackson
Joy Lazarus
Marcie Dear
Jim Martinez
Lee Price
Joel Rothenberg
Vickie Hite
William Hawkins
Jack Wood

ATTACHMENT A

SSA Teams for Care Management, Member Management and, Behavioral Health

SSA Team for Behavioral Health Business Relationship Management

Name
Michael Campfield
Cathy Pumphrey
Cheryl Chittum
Amanda J Currin
Paul Gilding
Amanda Goza
Marion Greenfield
Sanford Hostetter
Charles Law
David Lyon
Don Obenshain
David Ray
John Willinger

SSA Team for Behavioral Health Care Management

Name
Brenda Buenvenida
Cathy Pumphrey
Thomas Davies
Marion Greenfield
Andrew Heck
Mike Jones
Teresa Pigue
Lee Price
Valerie Pulliam
Priscilla Scherger
Dennis Shrewberry
Cheri Stierer
Michele Thomas Rx
Caroline Thompson

ATTACHMENT A

SSA Teams for Care Management, Member Management and, Behavioral Health

SSA Team for Behavioral Health Accountability Management

Robin Crews
Charles Felmlee
Ken Gunn
Cecil Hardin
David Mawyer
Michelle Porter
Valerie Pulliam
Joel Rothenberg
Randy Sherrod
Frank Tetrick
Peggy Waughan
Wanda Whittaker

MITA Functions to DMAS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
Member Management (ME)	ME Determine Eligibility	Carrie McDermott	Patty Taylor	Cindy Olson; Janice Holmes; Kelly Calder; Karen Packer; Karen Rowson; Melissa Fritzman; Mary Mitchell; Susan Offie; Jeral Mines	Receives application data, checks for status, establishes type of eligibility, verifies applicant information, assigns identifiers, associates with benefit packages, and notifications.
	ME Disenroll Member		Patty Taylor		Termination of a members (recipient) enrollment; notification to member and other related communication/outreach.
	ME Enroll Member		Patty Taylor		Determines additional qualifications for enrollment (MC, HIPP, Waiver etc.) Stores data and produces notifications to member and contractor.
	ME Inquire Member Eligibility		Patty Taylor		Inquiries for eligibility verification from providers, programs, or business associates.
	ME Manage Applicant and Member Communication		Patty Taylor		Requests for information, appointments, and assistance from prospective and current members (help desk etc.).
	ME Manage Member Information		Patty Taylor		Managing and maintaining enrollment records and data.
	ME Perform Population and Member Outreach		Patty Taylor		Notifying prospective applications and current members about new benefits and population health initiatives; new program initiatives; education (EPSDT/FAMIS).
	ME Manage Member Grievance and Appeal				Addresses applicant/member (or advocates) appeals of adverse decisions or communications of a grievance.

MITA Functions to DMAS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
Care Management (CM)	CM Establish	Karen Rowson		Melissa Fritzman, Rebecca Mendoza, Tammy Whitlock, Yvonne Goodman, Tabitha Taylor, Lothine Petway, Barry Horne, Brian Campbell and Meredith Lee	Uses criteria and rules to identify target member populations for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication.
	CM Manage Case	Karen Rowson		Melissa Fritzman, Tammy Whitlock, Yvonne Goodman, Tabitha Taylor, Lothine Petway, Barry Horne, Brian Campbell and Meredith Lee	CMS has provided no description of this business process other than that implied by its name.
	CM Manage Medicaid Population Health	Karen Rowson		Melissa Fritzman, Tammy Whitlock, Yvonne Goodman, Tabitha Taylor, Lothine Petway, Barry Horne, Brian Campbell and Meredith Lee	Designs and implements strategies to improve general population health through targeting individuals by cultural or diagnostic or other demographic indicators. The inputs to this process are census, vital statistics, immigration, and other data sources. The outputs are educational materials, communications, and other media.
	CM Manage Registry	Karen Rowson		Melissa Fritzman, Tammy Whitlock, Yvonne Goodman, Tabitha Taylor, Lothine Petway, Barry Horne, Brian Campbell and Meredith Lee	Operates a registry (such as for immunizations, cancer), receives continuous updates, responds to inquiries, and provides access to authorized parties.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
Client Management (CL)	CL Manage Client/Applicant Communication	Karen Rowson	William O'Bier	Amanda Goza, Don Obenshain, Florence Wells, Marion Greenfield, Michael Shank, Michelle Porter, Peggy Vaughan, Roberta Carey, Robin Crews, Sterling Deal, Teresa Pigue, Theresa Anderson, Thomas Davies, Wanda Whittaker	The Manage Client/Applicant Communication business process receives individual requests for information, appointments and assistance from prospective and current clients such as inquiries related to eligibility, programs and services, costs, and providers; and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and distributed electronically as appropriate. NOTE: The Perform Client/Applicant Outreach process targets both prospective and current client populations for distribution of information about programs, services, and health issues.
	CL Manage Client Grievance and Appeal				The Mange Client Grievance and Appeal business process receives data from the client or the client's agent or representative (Human Rights Councils, advocacy organizations, ACLU, facilities, etc.): records the problem, tracks the problem investigation, appeal and resolution process, and documents communications, dates and outcome; screens for required fields, edits required fields, verifies client information with external entities if available, assigns an ID, tracks the process and timeline, and records the final outcome.
	CL Manage Client Information				The Manage Client Information business process is responsible for managing all operational aspects of agency client data, which is the source of comprehensive information about applicants and clients, and their interactions with the state agency. The client database includes demographic, financial, socio-economic, treatment, service, health status, and outcomes information. Business processes that generate applicant or client information send requests to the client database to add, delete, or change this information. The client database provides access to client records to internal and external users.
	CL Inquire Client Information				The Inquire Client Information business process receives requests for client information from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set. The client database includes demographic, financial, socio-economic, treatment, service, health status, and outcomes information.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	CL Perform Population/Client Outreach				The Perform Population and Client Outreach business process originates internally within the Agency to identify and notify prospective and current clients about BH programs and services; create and provide linguistically and culturally appropriate information and educational materials to those same clients; and monitor outreach efforts and effectiveness. Client data is analyzed to develop outreach methods and materials and to target specific populations. NOTE: The Perform Population and Client Outreach process targets both prospective and current client populations. The Manage Client/Applicant Communication process provides assistance and responses to individuals.
Provider/Contractor Management (P/CM)	P/CM Close out Health Care Services Contract	Karen Rowson	William O'Bier	Cathy Pumphrey, Cecil Hardin, Jon Chapman, Ron Harris, John Jackson, Joy Lazarus, Marcie Dear, Jim Martinez, Lee Price, Joel Rothenberg, Vickie Hite, William Hawkins, Wood, Jack	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.
	P/CM Monitor Administrative Contract				The Monitor Administrative Contract business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.
	P/CM Award Health Services Contract				The Award Health Services Contract business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.
	P/CM Manage Health Services Contract				The Manage Health Services Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses. 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/CM Close-Out Administrative Contract				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.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	P/CM Award Administrative Contract				The Award Administrative Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses. 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/CM Manage Contractor Information				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.
	P/CM Support Contractor Grievance and Appeal				The Support Contractor Grievance and Appeal business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Contractor Communications process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are distributed to the contractor information file. The contractor is formally notified of the decision via the Send Outbound Transaction process. This process supports the Program Quality Management business area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. NOTE: States may define “grievance” and “appeal” differently, perhaps because of state
	P/CMInquire Contractor Information				The Inquire Contractor Information business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	P/CM Perform Potential Contractor Outreach				The Perform Potential Contractor Outreach business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures. For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs. For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives. Contractor outreach communications are distributed through various mediums via the Send Outbound 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/CM Manage Contractor Communication				The Manage Contractor Communication business process receives requests for information, appointments and assistance from contractor such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed and produced for distribution via the Send Outbound Transaction process. NOTE: Inquiries from prospective and current contractors are handled by the Manage Contractor Communication process by providing assistance and responses to individual entities, i.e., bi-directional communication. The Perform Contractor Outreach process targets both prospective and current contractor populations for distribution of information regarding programs, policies and other issues.
Operations Management (OM)	OM Authorize Referral	Karen Rowson	William O'Bier	Shaquwanda Baker, Debbie Bender, Cathy Pumphrey, Amanda J Currin, Olivia Garland, Paul Gilding, John Jackson, David Mawyer, Don Obenshain, David Ray, Florence Wells, Brian Whitesell	
	OM Authorize Service/Level of Service				The Authorize Service/Level of Service business process applies to a pre-approved or post-approved service or level of service request. This business process focuses on specific types and numbers of visits, specific services, court ordered treatment, service intensity, and institutional days of stay. Referrals are approved, modified, denied or pended for additional information.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	OM Apply Claim Attachment				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/contractor unsolicited, linking it with a trace number to associated claim, validating application level edits, determining if the data set provides all information necessary to adjudicate the claim.
	OM Apply Mass Adjustment				The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes involving many claims within a range of dates submitted by multiple provider/contractors. This mass adjustment business process includes identifying the claims that were paid incorrectly during a specified date range, applying parameters to reverse the paid claims and repay correctly. This business process often affects multiple providers/contractors as well as multiple claims. NOTE: This should not be confused with the claim adjustment adjudication process.
	OM Edit Claims-Encounter				The Edit Claim/Encounter business process receives an original or an adjustment claim/encounter data set and determines its submission status, and validates edits, service coverage and coding. The process sends validated data sets to Audit Claim/Encounter process and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process.
	OM Price Claim - Value Encounter				The Price Claim/Value Encounter business process begins with receiving a claim/encounter data set from the Audit Claim/Encounter process, applies pricing algorithms, calculates premiums, calculates and applies provider/contractor advances, and deducts recoupments. This process is also responsible for ensuring that all adjudication events are documented in the Payment History and are accessible to all Business Areas. NOTE: An adjustment to a claim follows generally the same process path.
	OM Prepare COB				The Prepare COB business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria. This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, and formatting of claims data into the outbound EDI data set.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	OM Prepare Premium EFT-check				The Prepare Premium EFT/Check business process manages the generation of electronic and paper based reimbursement instruments, including calculation of premium, application of automated or user defined adjustments based on contract, disbursement of premium, association with an X12 820 electronic premium payment transaction when necessary, routing the payment for electronic fund transfer (EFT) or check generation and mailing.
	OM Prepare Provider EFT-check				The Prepare Provider/Contractor EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including: • Calculation of payment amounts for a variety of claims including FFS, pharmacy, and encounters, and the 1099 process • Disbursement of payment from various funding sources • Associating EFT with an X12 835 electronic remittance advice transaction • Routing the payment for EFT or check generation and mailing
	OM Prepare Remittance Advice-Encounter Report				The Prepare Remittance Advice/Encounter Report business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers/contractors 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. NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.
	OM Prepare Grants/Cost Based Payment/Invoice				The Prepare Grants/Cost-Based Payment/Invoice business process is scheduled as stipulated by Trading Partner Agreement and includes retrieving and converting transaction data. The process includes receiving provider/contractor invoices, retrieving provider/contractor and service data, retrieving the contracted/cost-based rate data associated with the services, formatting the results into required output data set, and producing invoices to be processed through the agency payment system.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	OM Prepare Capitation Premium Payment				The Prepare Capitation Premium Payment business process includes premiums for Managed Care Organizations (MCO), Behavioral Health Organizations (BHO), and other capitated programs. This process is scheduled as stipulated by Trading Partner Agreement and includes retrieving intake/enrollment and service transaction data, retrieving the associated rate data, and formatting the payment data into the required outbound transaction data set. NOTE: This process does not include sending the capitation payment data set.
	OM Prepare Health Insurance Premium Payment				The Prepare Health Insurance Premium Payment business process begins by receiving eligibility information via referrals from providers/contractors, institutions, community services organizations, or phone calls directly from clients; checking for eligibility status with other payers, editing required fields, producing a report, and notifying clients. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. NOTE: This process does not include sending the health insurance premium payment data set.
	OM Prepare Medicare Premium Payment				The Prepare Medicare Premium Payment business process begins with a reciprocal exchange of eligibility information between Medicare and the BH 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 BH client data, generating buy-in files for CMS for verification, and formatting the premium payment data into the required output data set. NOTE: This process does not include sending the Medicare premium payments EDI transaction.
	OM Inquire Payment Status				The Inquire Payment Status business process begins with receiving a claim status inquiry via paper, phone, fax or 276 EDI transaction 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.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	OM Manage Payment Information				The Manage Payment Information business process is responsible for managing all the operational aspects of the Payment Information Repository, the source of comprehensive payment information made to and by the state BH agency for health care and support services. These processes send requests to add, delete, or change data in payment records from exchanges with other payment processes.
	OM Calculate Spend-Down Amount				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. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels. The Calculate Spend-Down Amount business process begins with the receipt of client eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the client is assigned to a benefit package or program that requires a predetermined amount the client must be financially responsible for prior to Medicaid payment for any medical services.
	OM Develop Sliding Scale				The Develop Sliding Scale business process begins with estimating the average client's ability to pay, usually as compared to current Federal Poverty Level data, and assigning a percentage to successive dollar ranges equivalent to client resources. Agencies may also factor in the available budget and estimated client load in setting the scale.
	OM Determine Client Contribution				The Determine Client Contribution business process describes the process by which client contribution towards payment is calculated. Fees may be assessed based on the client's ability to pay when certain services are not covered by other funding sources. NOTE: VA CSBs fees are assessed whether the service is covered or not; copays are not an either, or. The Determine Client Contribution business process begins with the evaluation of a client's financial means to determine ability to pay, usually as compared to the Federal Poverty Level. When a service is rendered, the client's ability to pay is reviewed against the service fee, and the fee is computed as a percentage of the service fee.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	OM Prepare Client Invoice				The Prepare Client Invoice business process begins with a scheduled invoicing timetable. The process includes retrieving client contribution data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing client invoices to recoup client fees.
	OM Collect Client Fees				The Collect Client Fees business process begins with receiving client payment per an agency invoice. The process includes documenting the payment, entering the remittance amount, processing the payment, and formatting the results into required output data set for the accounting process.
	OM Manage Drug Rebate				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.
	OM Manage Estate Recovery				Estate recovery requires States to recover certain Medicaid benefits correctly paid on behalf of an individual, usually when permanently institutionalized. 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, generating notice of intent to file), opening formal estate recovery case, determining value of estate lien, files estate claim of lien, and conduct case follow-up.
	OM Manage Recoupment				The Manage Recoupment business process describes the process of managing provider/contractor recoupment initiated by the discovery of an overpayment. The process then retrieves claims payment data, initiating the recoupment request, or adjudicates the claims adjustment request, notifying the provider/contractor of audit results, finally applying the refund in the system and monitoring payment history until the repayment is satisfied.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	OM Manage Settlement				The Manage Settlement business process begins with requesting annual claims summary data from the payment history, reviewing provider/contractor costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider/contractor cost settlement data, calculating the final annual cost settlement, generating and verifying the data, producing provider/contractor notifications, and establishing interim reimbursement rates, sending the cost settlement data set and tracking settlement payments.
	OM Manage TPL Recovery				The Manage Third Party Liability (TPL) Recovery business process receives third party liability data from various sources such as external and internal data matches, referrals, Attorneys, Fraud and Abuse units, providers/contractors and insurers, identifies the provider/contractor or TPL carrier, locates recoverable claims from payment history, creates post-payment recovery files, sends notification to other payers or providers/contractors, receives payment, sends receivable data, and updates payment history.
Program Management (PM)	PM Develop Agency Goals and Initiatives	Karen Rowson	William O'Bier	Sharon.Becker, Robin.Crews, Charline.Davidson, Mark.Diorio, Wanda.Fitzgerald, Ken.Gunn, Sanford.Hostetter, Jim.Martinez, Vicki.Montgomery, Priscilla.Scherger, Joy.Yeh	The Develop Agency Goals and Initiatives business process periodically assesses 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 hurricanes, fires and floods.
	PM Develop and Maintain Program Policy				The Develop and Maintain Program Policy business process responds to requests or needs for change in the agency's programs, services, 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 and advocate pressure.
	PM Formulate Budget				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.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	PM Manage Federal Funds				Funding sources for BH services may come from a variety of sources and are often spread across programs. The Manage Federal Funds business process monitors federal funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.
	PM Manage Block Grants				Funding sources for BH services may come from a variety of sources and are often spread across programs. The Manage Block Grants business process monitors federal funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.
	PM Identify Services Provided through Block Grants				The Identify Block Grant Services business process determines the services to be supported through grants. The process examines current state needs, services and trends, estimates service costs, obtains planning council and other stakeholder input, assesses external factors affecting the service plan, assesses agency initiatives and plans, and produces a final service plan.
	PM Monitor Block Grant requirements				The Monitor Block Grant Requirements business process monitors the services provided and outcomes achieved through block grant funding. The process regularly examines the most current provider/contractor data on service delivery and costs, service coverage and improvement, client outcomes, grant expenditures and other factors as required by the grant.
	PM Manage State Funds				Funding sources for BH services may come from a variety of sources and are often spread across programs. The Manage State Funds business process monitors state and other funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	PM Manage 1099s				The Manage 1099s business process describes the process by which 1099 tax forms are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number. The process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Manage Settlements process. The 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 as needed. 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.
	PM Perform A-133 Provider Audits				The Perform A-133 Provider Audits business process describes the process by which the agency requests and receives audits required by Federal grant recipients. The process involves reviewing audits, and conducting follow up on findings and questionable costs. The OMB A-133 compliance supplement is an extensive guide for auditing Federal grants and their respective recipients.
	PM Generate Financial and Program Analysis Reports				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, service codes, provider/contractor types and specialties (taxonomy), retrieving data from multiple internal sources, compiling the data, and formatting into the required data set. NOTE: This process does not include maintaining service, reference, or program information.
	PM Manage Program Information				The Manage Program Information business process is responsible for managing all the operational aspects of the Program Information Repository, the source of comprehensive program information used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information Repository receives requests to add, delete, or change data in program records.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	PM Respond to Consent Decrees				The Respond to Consent Decrees process receives and requests consent permissions, stores those permissions, locates the permissions when a specific client's information is requested, ensures that the permissions are followed, and forwards the permissions with the requested data.
Business Relationship Management (BR)	BR Create Business Relationship	Karen Rowson	William O'Bier	Michael Campfield, Cathy Pumphrey Cheryl Chittum, Amanda Currin, Paul Gilding, Amanda Goza, Marion Greenfield, Sanford Hostetter, Charles Law, David Lyon, Don Obenshain, David Ray, John Willinger	The Create Business Relationship business process encompasses activities undertaken by the State BH agency to enter into a variety of business partner relationships, usually with other government agencies. These arrangements include Memoranda of Understanding (MOUs), interagency contracts and service agreements, health information exchange (HIE) agreements, access and capacity agreements
	BR Manage Business Relationship				The Manage Business Relationship business process maintains the agreement between the State BH agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards.
	BR Manage Business Relationship Communications				The Manage Business Relationship Communication business process produces and assures routine and ad hoc communications between the business partners.
	BR Create Communications Protocols				The Create Communications Protocols business process establishes mechanisms and requirements for routine and ad hoc communications between agency business partners. This requirement at present primarily governs communications protocols between substance abuse agencies, child welfare agencies and the courts, where consideration of the confidentiality requirements and legal requirements on all sides is critical to determine what data can be shared. It was noted that this description appears to be out of date because it doesn't reference HIPAA.
	BR Create Block Grant Applications				The Create Block Grant Applications business process encompasses activities undertaken by the BH agency to solicit provider and contractor applications to provide services.
	BR Engage in Joint Planning				The Engage in Joint Planning business process coordinates efforts and programs between agency business partners that have similar goals, objectives, and target populations. Although the goals and objectives may be similar, the specific activities undertaken are often very different but may represent complementary approaches, or comprehensive approaches when combined, to improving client health, treatment, and services.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	BR Terminate Business Relationship				The Terminate Business Relationship business process cancels the agreement between the State BH agency and the business partner.
Accountability Management (AM)	AM Initiate Case	Carrie McDermott	William O'Bier	Robin Crews, Charles Felmlee, Ken Gunn, Cecil Hardin, David Mawyer, Michelle Porter, Valerie Pulliam, Joel Rothenberg, Randy Sherrod, Frank Tetrick, Peggy Vaughan, Wanda Whittaker	The Initiate Case business process uses criteria and rules to identify patterns or parameters of acceptable/unacceptable behavior, determine when action is needed, and open a case for further investigation. Each type of case is driven by different criteria and rules, different relationships, and different data.
	AM Manage Case				The Manage Case business process receives a case file from an investigative unit with the direction to respond to the case, participate in the case, or pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or client from the program; or the case may be terminated or suspended. 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.
	AM Manage Disallowances				The Manage Disallowances process monitors and helps assure provider/contractor compliance with requirements for receiving funding and reimbursement. The process assists providers/contractors in adopting documentation and business practices that support obtaining sufficient and appropriate revenue, and protect them from vulnerability to revenue reductions. Different payers may have different criteria and rules.
	AM Perform Block Grant Reviews				The Perform Block Grant Reviews process conducts an evaluation of the provider/contractor proposals submitted in response to block grant RFPs. The block grant application process is the formal mechanism for distributing federal block grant funds. The review process involves a team of experts who review and score each proposal. The final score is considered in determining funding allotments.
	AM Conduct Routine Fiscal and Clinical Monitoring				The Conduct Routine Fiscal and Clinical Monitoring business process monitors services, outcomes, and expenditures required to meet state and Federal reporting requirements. The process regularly examines the most current client, service, and provider/contractor data on service delivery and costs, service coverage and improvement, client outcomes, expenditures and other factors as required.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	AM Develop and Manage Performance Measures and Reporting				The Develop and Manage Performance Measures and Reporting business process establishes mechanisms and requirements for developing, managing, and reporting performance measures and other data for providers/contractors, quality, and outcomes, and to comply with state and federal reporting requirements. This process analyzes client and service histories and trends, costs, expenditures, and trends, assesses external factors affecting the program, assesses agency initiatives and plans, identifies significant measurable activities and outcomes, and creates and/or revises performance measures.
	AM Monitor Performance and Business Activity				The Monitor Performance and Business Activity process utilizes the mechanisms and measures that were developed by the agency. The process includes the steps involved in implementing the mechanisms and measures to track agency activity and effectiveness at all levels. Examples include episodes of care, performance measures, outcomes measures, and quality measures.
	AM Initiate Accreditation Process				The Initiate Accreditation process provides assistance to providers/contractors in achieving and maintaining the accreditation and credentialing necessary for program participation.
Care Management (CM)	CM Discharge Client	Karen Rowson	William O'Bier	Brenda Buenvenida , Cathy Pumphrey , Thomas Davies , Marion Greenfield , Andrew Heck , Mike Jones , Teresa Pigue , Lee Price , Valerie Pulliam , Priscilla Scherger , Dennis Shrewsberry, Cheri Stierer , Michele Thomas , Caroline Thompson	The Discharge Client business process is responsible for managing the termination of a client's stay in a facility or participation in a program, for any reason. The process uses data from the Admit/Enroll Client process and from client data and records gathered throughout the period of service, validates the discharge data,
	CM Coordinate/Manage Case				The Coordinate/Manage Case business process uses Federal and State-specific criteria and rules to ensure appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for clients. It includes activities to confirm delivery of services and compliance with the plan, as well as service planning and coordination, brokering of services (finding providers, establishing service limits, etc.), continuity of care, and advocating for the client.

BH-MITA Functions to DMAS/DBHDS Organizational Mapping

Business Area	Business Process	Facilitator	Primary SME	Other Analysts/SMEs	Comments
	CM Manage and Monitor Client and Treatment Outcomes				The Manage and Monitor Client and Treatment Outcomes business processuses Federal and State-specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes client and client population outcomes. It includes activities to track and assess effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. It also includes ongoing monitoring, management, and reassessment of services and treatment plans for need, appropriateness, and effectiveness, and monitoring of special client populations (block grant, pregnant women and children, and HIV/intravenous drug users).
	CM Develop Treatment Plan Goals, Methods, and Outcomes				The Develop Treatment Plan Goals, Methods, Outcomes business process uses Federal and State-specific criteria, rules, best practices and professional judgment to develop client treatment plans that optimizes successful outcomes. It includes involving a team of professionals to engage in activities to track and assess the client and his/her treatment progress both on intake and throughout the care process, establish and adapt a care plan tailored to changing client needs, and establish achievable goals and an appropriate mix of treatment and support services.
	CM Develop Discharge Planning and Aftercare Plan				The Develop Discharge Planning and Aftercare Plan business process uses Federal and State-specific criteria, rules, best practices and professional judgment to develop discharge planning and aftercare plans that optimize successful outcomes. It includes activities to track and assess the client and his/her treatment progress during the episode of care and status at discharge, evaluate client needs for ongoing care and support services, and establish a long term plan for continuing and/or sustaining recovery.
	CM Prevention				The Prevention business process provides training, education and support to vulnerable populations to assist in preventing individuals from engaging in harmful behaviors and provide support for recovering clients.

MITA STATE SELF-ASSESSMENT
PROCESS REVIEW SCHEDULE

Business Process Area	*Business Process Name*	*IM Analyst*	*October*	*November*	*December*	*January*	*February*	*March*
Care Management	Establish Case BCM/BPM	Karen Rowson	10/27					
	Manage Case BCM/BPM							
	Manage Registry BCM/BPM							
	Manage Medicaid Population Health BCM/BPM							
Member Management	Determine Eligibility BCM/BPM	Carrie McDermott			12/1			
	Disenroll Member BCM/BPM				12/8			
	Enroll Member BCM/BPM							
	Inquire Member Eligibility BCM/BPM				12/15			
	Manage Applicant and Member Communication BCM/BPM							
	Manage Member Grievance & Appeal BCM/BPM				12/22			
	Manage Member Information BCM/BPM					1/5		
	Perform Population and Member Outreach BCM/BPM							
BH Client Management	Manage Client Information	Karen Rowson	10/28					
	Inquire Client Information							
	Manage Client/Applicant Communication			11/4				
	Manage Client Grievance and Appeals							
	Perform Population and Client Outreach							
BH Accountability Management	Perform Block Grant Reviews	Carrie McDermott			12/2			
	Manage Disallowances							
	Manage Case							
	Initiate Case							
	Conduct Routine Fiscal and Clinical Monitoring				12/16			
	Develop and Manage Performance Measures and Reporting							
	Initiate Accreditation Process							
	Monitor Performance and Business Activity							
BH Care Management	Screening and Assessment	Karen Rowson				1/6		
	Referral Placement							
	Manage Wait List							
	Intake Client							
	Prevention					1/13		
	Manage and Monitor Client and Treatment Outcomes							
	Discharge							
	Develop Treatment Plan, Goals, Methods and Outcomes							
	Develop Discharge Planning and Aftercare Plan							
	Coordinate Manage Case							
	Admit Enroll Client BCM							

MITA STATE SELF-ASSESSMENT
PROCESS REVIEW SCHEDULE

Business Process Area	*Business Process Name*	*IM Analyst*	*October*	*November*	*December*	*January*	*February*	*March*
BH Program Management	Identify Block Grant Services	Karen Rowson				1/27		
	Develop Agency Goals and Initiatives							
	Develop and Maintain Program Policy							
	Manage Block Grants							
	Monitor Block Grant Requirements							
	Formulate Budget						2/3	
	Manage State Funds							
	Manage 1099s							
	Perform A-133 Provider Audits							
	Respond to Consent Decrees							
	Generate Financial and Program Analysis Reports						2/10	
	Manage Program Information							
BH Operations Management	Authorize Referral	Karen Rowson					2/17	
	Authorize Service/Level of Service							
	Apply Claim Attachment							
	Apply Mass Adjustment							
	Edit Claims-Encounter							
	Price Claim - Value Encounter							
	Prepare COB							
	Prepare Premium EFT-check							
	Prepare Provider EFT-check							
	Prepare Remittance Advice-Encounter Report							
	Prepare Grants/Cost Based Payment/Invoice							
	Prepare Capitation Premium Payment							
	Prepare Health Insurance Premium Payment							
	Prepare Medicare Premium Payment							
	Inquire Payment Status							
	Manage Payment Information							
	Calculate Spend-Down Amount							
	Develop Sliding Scale							
	Determine Client Contribution							
	Prepare Client Invoice							
	Collect Client Fees							
	Manage Drug Rebate							
	Manage Estate Recovery							
	Manage Recoupment							
	Manage Settlement							
	Manage TPL Recovery							

MITA STATE SELF-ASSESSMENT
PROCESS REVIEW SCHEDULE

Business Process Area	*Business Process Name*	*IM Analyst*	*October*	*November*	*December*	*January*	*February*	*March*
BH Provider/Contractor Management	Monitor Administrative Contract Award Health Services Contract Close-Out Health Care Services Contract Manage Health Services Contract Close-Out Administrative Contract Award Administrative Contract Manage Contractor Information Support Contractor Grievance and Appeal Inquire Contractor Information Perform Potential Contractor Outreach Manage Contractor Communication	Karen Rowson						3/3
BH Business Relationship Management	Create Business Relationship Manage Business Relationship Manage Business Relationship Communications Create Communications Protocols Create Block Grant Applications Engage in Joint Planning Terminate Business Relationship	Karen Rowson						3/17
			2	1	6	4	3	2

BH MITA BCM
ISSUES, QUESTIONS, and SUGGESTIONS

Item #	Business Area/ Process or General	Submitted by	[I]ssue/[Q]uestion/[S]uggestion
1.	Business Relationship Management: Create Communications Protocols	K. Rowson	I: The process description seems out dated because it does not reference HIPAA.
2.	Operations Management: Authorize Service/Level of Service; Level 2	K. Rowson	Q: Should the reference to HIPAA Standard, X 12 277/278 be separated since there is no relationship between the 2 transactions. The 277 is the claims status response and is usually associated with the 276 claims inquiry. The 278 is the referral certification and authorization.
3.	Operations Management: Collect Client Fees, Prepare Client Invoice; Level 2	K. Rowson	Q: Why is this statement relevant: Grants/cost-based payments are aligned to the HIPAA standards.
4.	Operations Management: Globally	K. Rowson	I: Out of the 26 business processes in this area, only 6 could be assessed. The processes related to payment could not be assessed as DBHDS does not have a mechanism for paying providers. Is this a unique or common occurrence among state mental health agencies?
5.	Program Management: Globally	K. Rowson	I: Level 3 requirement for the use of HL7 does not seem appropriate for this business area as many of the processes are not health care related.
6.	Provider/Contractor Management : Monitor Administrative Contract	K. Rowson	I: There is no identifiable standard to aspire to throughout this business area.

Accountability Management (AM)

AM: Conduct Routine Fiscal and Clinical Monitoring Process				
Item	**Details**			
Description	The ***Conduct Routine Fiscal and Clinical Monitoring*** business process monitors services, outcomes, and expenditures required to meet state and Federal reporting requirements. The process regularly examines the most current client, service, and provider/contractor data on service delivery and costs, service coverage and improvement, client outcomes, expenditures and other factors as required.			
MITA Reference	Source Process Name: *Conduct Routine Fiscal and Clinical Monitoring* Source Process Business Area: *Accountability Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client Information Outcomes and performance measures Budget and expenditure history		Services information Provider/contractor history Conceivably, all enterprise data	
AM: Conduct Routine Fiscal and Clinical Monitoring: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is done with a mix of tape, CD and some proprietary internal systems, using nonstandard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and multiple reviews may be conducted by different programs. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. The process is informed by a set of agency standardized data on clients, services and outcomes. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external data and stakeholders. Coordination cross agency improves coordination of monitoring activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Client, service, and provider/contractor information is accessible to any authorized party through HIEs statewide for monitoring purposes. This Level adds clinical data.	Client, service, and provider/contractor information is accessible to any authorized party through HIEs nationwide for monitoring purposes. This Level adds nationwide technical interoperability.
VA As Is:				
VA To Be:				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				

SAMPLE

Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

SAMPLE

ATTACHMENT B

ME Determine Eligibility

Determine Eligibility		
Item	**Details**	**VA "As-Is" Details**
Description	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. **NOTE:** A majority of States accept the designation of eligibility from other agencies (SSI, TANF, SCHIP, and 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 data store. This may require conversion of the data. 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.	{2}. Attachment A missing {3} Eligibility determination is done by the Virginia Dept. of Social Services (Medicaid) and a contractor (ACS – SCHIP/FAMIS). Some eligibility determination is done by DMAS as well (TDO etc.). There is no eligibility determination done using the MMIS as a tool; it records the results of the determination. {4} Examples include: HIV, TDO, Premium Assistance
Trigger Event	1. Interaction-based Trigger Event: 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. a. Spend down calculation or data b. Calculate cost share	
Result	1. Eligibility application status set to: accepted, denied, or pended for research/additional information. 2. Eligibility is determined as approved, denied, pended for additional information or review, or cancelled. 3. Member eligibility record completed and sent to ***Manage Member Information*** to process and load into Member data store. 4. Member notification prepared and data set sent to the ***Manage Applicant and Member Communication*** process. 5. Tracking information regarding the interchange as needed for the ***Determine Eligibility*** process, measuring performance and business activity monitoring. 6. Feed into ***Enroll Member*** for Managed Care.	1&2. Virginia doesn't "pend" eligibility applications. Currently, the applications are only input when all information is available and eligibility has been determined.

ME Determine Eligibility

Determine Eligibility		
Item	**Details**	**VA "As-Is" Details**
Business Process Steps	1. Start: Receive eligibility application data set (cover all trigger events i.e., time events). 2. Verify status of application (new, resubmit, duplicate, and 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: a. 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, and SSA. b. 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. c. For spend down applicants, verify that qualifying medical care expenditures amount has been met. d. Verify resource eligibility. Apply resource standard (dollar amount) and methodology (rules for which assets are counted and how they count); verify applicant documentation. e. Verify immigrant status. Determine which immigrant classification the individual belongs to (if applicable); verify documentation.	5. Virginia has no mandatory face-to-face interview requirement.

ME Determine Eligibility

Determine Eligibility		
Item	**Details**	**VA "As-Is" Details**
Business Process Steps (Cont'd)	f. Verify residency. Check documentation proving residency in the State (Note, if institutionalized in another State, eligibility stays with State of residency) g. Verify other coverage. Validate information supplied by applicant; verify with other coverage sources not referenced by applicant. 6. For Applicants, verify the following: 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. 7. Determine eligibility for QMB, SLMB. 8. For disabled applicants, verify disability. Determine that applicant meets disability qualifications. 9. For pregnant women, verify pregnancy. 10. Apply composite eligibility determination rules — summation of all rules determines if applicant is eligible or not, and if eligible, for which category of eligibility. 11. 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, and Indian Health Service. 12. Assign I.D. 13. Assign eligibility category (ies) [some children in family may not be eligible for Medicaid, e.g., too old to qualify for income level]. 14. 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?] 15. Load eligibility information into Member data store 16. End: Request that the ***Manage Applicant and Member Communication*** process generate notifications.	11. DMAS Accepts declarations unless they are questioned. 18. DMAS does use a hierarchy. DMAS refers applicants to other programs but does not determine eligibility. 21. DMAS doesn't have a single source. The Medicaid, MCO, and FAMIS handbooks are on the Internet and available to the public. The MMIS benefit reports contain benefit package details. Medicaid and FAMIS references (handbooks under the "Client Services" section of the DMAS home page): http://www.dmas.virginia.gov/ Managed care references: http://www.dmas.virginia.gov/mc-home.htm MMIS benefit package reports are generated on demand by DMAS. Reports available: • RS-O-080, Benefit Package Enrollment Rules Report. Shows by benefit package, all the associated enrollment rules, its effective dates, its related values, and the values effective dates. • RS-O-090, Aid Category Eligibility Rules Report. Listed by aid category (A/C) showing data for the A/C, the benefit plans related to the A/C, and eligibility rules and rule values by relationship code for the A/C.

ME Determine Eligibility

Determine Eligibility		
Item	**Details**	**VA "As-Is" Details**
Shared Data	1. Member data store and custodial information; school, special schools tuition. 2. Eligibility Categories and Hierarchy Table 3. Benefit Plans and Associated Services Table 4. TANF eligibility 5. SSI eligibility 6. SSP eligibility 7. Spend down amount data store 8. Veterans Administration 9. Indian Health Service 10. INS 11. Other insurers and type of coverage 12. Bank account balances 13. Employer records 14. Fraud case file 15. Vital Statistics 16. Aging or elderly services	
Predecessor	1. Receive inbound transaction process; receives paper and/or 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.	2. DMAS doesn't do presumptive eligibility determination.
Successor	1. Notify applicant, member being redetermined or guardian. 2. Update Member data store.	
Constraints	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.	DMAS doesn't automatically accept eligibility with TANF today.

ME Determine Eligibility

Determine Eligibility		
Item	**Details**	**VA "As-Is" Details**
Failures	A member eligibility application may fail at the following steps: 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. Verification with internal or external sources. **Note**: 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.	
Performance Measures	1. Time to complete eligibility determination process = ___ days 2. Accuracy of decisions = ___% 3. Consistency of decisions and disposition = ___% 4. Error rate = __% or less	*1. Measures are available in section M0130 of the Medicaid Eligibility Manual and the Medicaid Handbook.* Handbooks under the "Client Services" section of the DMAS home page: http://www.dmas.virginia.gov/ *2. DMAS is working on this.*

Determine Eligibility Business Capabilities

Member Management: Determine Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Business Capability Descriptions **The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.**				
How does the applicant complete and submit the application?	Applicant completes application on paper with submissions being faxed, hand-delivered, or mailed.	Applicant may use paper application but also has choices of data entry at government offices and kiosks. Electronic submissions are available and used.	Applicants may complete and submit electronic applications from any location that has internet access; there is a uniform application process for multiple programs, including Medicaid.	
Does the application use standardized format and data content?	Data and format are indeterminate. Requirements are locally defined.	Application data are standardized within the Medicaid enterprise.	Application data are standardized using MITA standard interface and data content specifications across multiple programs.	
How is application data validated?	Information is manually validated. Staff contact external and internal document verification sources via phone, fax, USPS. Decisions on data verifications take several days.	Many application data validations are automated (SSA, address, birth certificate, etc.).	Electronic messages and automatic data matching are sent to external entities such as banks for financial verification, employers for wage verification and employment dates, to state and federal tax authorities, insurance companies to verify TPL using MITA standard interfaces.	

Member Management: Determine Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
How consistent are the decisions?	Decisions have a degree of inconsistency due to individual interpretation and application of policies.	Consistency improves with the automation of some processes.	With increased automation, rules are consistently applied and decisions are uniform. Exceptions are minimal and reviewed for quality improvement to reduce future need.	
How integrated is the eligibility determination process?	There are many pathways for determining eligibility. Eligibility determination may occur in silos without sharing or coordination, i.e., different processes for each type of eligibility.	Eligibility determination is automated to assist staff in processes. For example, social services staff could access web portal to begin process of Medicaid application or single application form may be used across agencies.	Different types of eligibility pathways are merged into a single electronic standard process through interagency agreements for multiple benefit assistance programs.	
Va. As Is:		At this level, the Determine Eligibility business process is extended by "work-arounds" to meet the needs of programs besides FFS. 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. Application data may be standardized within the state. Some applications still on		

Member Management: Determine Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		paper. Verifications are a mix of manual and automated. Consistency is improved. Requires fewer staff. Process takes less time than Level 1. There are many pathways for determining eligibility for low income applicants. At Level 2, eligibility determination may still occur in silos without sharing or coordination. Some efforts are made toward standardizing eligibility determination data so that it is more easily shared and compared. Spend-down continues to be calculated manually. DMAS has some No Wrong Door initiatives, some electronic application capabilities, and some consumer driven health care choices.		
Va. To Be:		DMAS will expand its No Wrong Door initiative. Consumer directed services will also be expanding. For instance, a Money Follows the Person initiative is underway.		
Business Capability Quality: Timeliness of Process				
How timely is the End to	The process can require	The process time is	The process time is	

Member Management: Determine Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
End process?	many days to receive the application, validate key data, determine eligibility and transfer information to the MMIS.	reduced due to applications being received on-line and some automation, but may continue to require many days to validate key data, determine eligibility and transfer information to the MMIS.	generally reduced to 24 hours due to on-line application processes using MITA standard interface and validations.	
Va. As Is:	Business processes do not meet thresholds for timeliness 100% of the time.			
Va. To Be:	DMAS would like to improve its timeliness and its data sharing.			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Data is entered by hand into the application and keyed in by staff. There are inconsistencies and errors that need correction.	Information in the member data store conforms to business rules. Information gathered externally is subject to errors.	Information conforms to MITA standards including interfaces with external data sources.	
How accessible is the information used in this process?	Access to bank account, residence requirements, citizenship information all require manual contact via phone, fax, or United States Postal Service (UPSP).	Information in the member data store is instantly accessible. External validations may still be via phone, fax, or USPS.	Internal and external data is instantly available via messaging.	
Va. As Is:		DMAS has some automation and standardization that improves consistency and accuracy.		
Va. To Be:		DMAS is working toward total automation and		

Member Management: Determine Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		standardization.		
Business Capability Quality: Cost-Effectiveness				
What is the ratio for the cost of eligibility determination compared to the value of the results?	Process is labor intensive and takes away from personal interactions with applicants.	Automation of business rules for eligibility determination improves the effectiveness of the process and allows staff to focus on difficult cases.	Use of MITA aligned business service interfaces and messaging with external entities streamlines this process allowing staff more time with applicants.	
Va. As Is:	The process requires a sizable staff, which is currently inadequate.			
Va. To Be:	DMAS will become more consistent and accurate through automation.			
Business Capability Quality: Effort to Perform; Efficiency				
How do you describe the efficiency of the Determine Eligibility process?	Manual workflow is burdensome. Some applicants experience delays in obtaining eligibility.	Automation increases efficiency and reduces delays in obtaining eligibility.	Use of national MITA standards and uniform data and processes among participating entities improves efficiency and further reduces delays in obtaining eligibility.	
Va. As Is:	Most business processes are labor-intensive and “stovepiped			
Va. To Be:	DMAS will work to connect its “stovepipes” and further reduce manual intervention via MITA initiatives.			
Business Capability Quality: Accuracy of Process Results				
What is the quality of the results of the process?	Manual processes can result in inaccurate eligibility determinations.	Accuracy of results is higher than at Level 1	Accuracy of the results is 98% or higher.	
Va. As Is:	Business process is labor-			

Member Management: Determine Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	intensive, but results do not meet requirements for timeliness and accuracy 100% of the time.			
Va. To Be:	DMAS wants to improve it timeliness and accuracy.			
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholder?	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.	
Va. As Is:		DMAS has automation that benefits stakeholders.		
Va. To Be:		DMAS hopes to provide recipients access to their data and provide timelier processing through automation.		

ME Disenroll Member

Disenroll Member		
Item	**Details**	**VA "As-Is" Details**
Description	The ***Disenroll Member*** business process is responsible for managing the termination of a member's enrollment in a program, including: ■ Processing of eligibility terminations and requests for disenrollment – 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 Premium Invoice** process for continued failure to pay premiums or Program Integrity business area for fraud and abuse – Mass Disenrollment due to changes in status, or termination of, program provider or contractor ■ Validation that the termination meets state rules ■ Requesting that the **Manage Member Information** process reference 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: – The **Prepare Capitation Premium Payment** and **Prepare Member Premium Payment** business processes for changes in Member Information and stored data for payment preparation – The appropriate communications and outreach and education processes, such as the **Manage Applicant and Member Communication, Perform Population and Member Outreach,** and **Manage Member Grievance and Appeal** business process. for follow up with the affected parties, including informing parties of their procedural rights (Note: This may precede *or* follow termination procedure(s)) Enrollment brokers may perform some of the steps in this process	Virginia uses some automated and some manual processes to accomplish this process. The level of automation/manual processes varies by program.

ME Disenroll Member

Disenroll Member		
Item	**Details**	**VA "As-Is" Details**
Trigger Event	Receipt of disenrollment request data set from the **Determine Eligibility** process (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 – where eligibility is based on health status (e.g., an AIDS Drug Assistance Program (ADAP), Home and Community Based Services, a Maternity Case Management, etc.) (Note: The other program may have a funding source separate from Medicaid.) 1. From Program Integrity, **Manage Case** – a fraud and abuse investigation results in disenrollment 2. From a member to change MCO, PCCM, or waiver provider, which is forwarded by the **Perform Applicant and Member Communication** process: (a) During an Open Enrollment period (b) As permitted by state rules, e.g., (i) Due to change in residence (ii) Because a provider whom the member has chosen no longer contracts with current program/MCO (iii) The contract with the member's MCO is terminated (iv) As a result of successfully appealing auto-assignment (v) The member has issues with the MCO, PCCM, or waiver provider that may impact quality of care 3. From 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 Communication** or **Manage Contractor Communication** processes 4. Receipt of information indicating change in eligibility status from the **Manage Member Communication** or **Manage Member Information** processes (a) Date of death file indicates member is deceased (b) Notification of incarceration (c) State of residence change	Virginia also has the following trigger events for disenrollment: return mail, failure to meet eligibility requirements such as aging out and failure to return application. There are also trigger events based on claims.

ME Disenroll Member

Disenroll Member		
Item	**Details**	**VA "As-Is" Details**
Result	1. Member is either or both a. Disenrolled from specific programs and/or from specific program contractors and/or providers b. Offered enrollment in alternative programs and/or with alternative contractors where the member meets program criteria 2. Member Information data store is updated, disenrollment data required for operations is made available, and alerts are broadcast to interfacing processes such as Care Management, **Establish Case** the **Prepare Capitation and Premium Payment** and **Prepare Member Premium Payment Invoice** business processes, the **Perform Applicant and Member Outreach**, and the Communication processes 3. Member and program contractor or provider are notified about intent to disenroll, followed by disenrollment results through the **Manage Applicant and Member Communication** business process. 4. Capitation or premium payments reflect the change in enrollment	2. Virginia doesn't charge premiums.

ME Disenroll Member

Disenroll Member		
Item	**Details**	**VA "As-Is" Details**
Business Process Steps	1. Start: Receive member eligibility termination data and/or disenrollment requests from the **Determine Eligibility**, the **Perform Applicant and Member Communication**, the **Manage Provider Communication** or the **Manage Contractor Communication** processes or external data sources 2. Assign unique identifier to request for tracking process through to completion, Include 'tags' to identify source and type of disenrollment request 3. Track processing status of eligibility termination and disenrollment requests (e.g., new, resubmission, duplicate) 4. Validate that request meets state disenrollment rules, [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 disenrollment, and to deactivate or reactivate. 5. Produce disenrollment record data set and request that the **Manage Member Information** process load disenrollment record into Member Information data store 6. Alert the **Manage Applicant and Member Communication, Manage Provider Communication**, **and Manage Contractor Communication** processes that new or updated disenrollment information has been loaded into the Member Information data store and request that these processes prepare notifications to the affected parties. This will likely include notification of appeal rights 7. Alert **Perform Applicant and Member Outreach** process to provide outreach and education materials needed by members who have been disenrolled in accordance with rules 8. End: Alert the appropriate Operations Management Area processes, e.g., the Capitation and Premium Payment business processes to prepare enrollment payment reflecting deletions; and notify the **Prepare Member Premium Invoice** business process to cease billing member for premiums (if applicable).	2. Virginia doesn't assign a unique identifier for tracking. 4 & 5. Virginia does these steps for managed care assignment of benefits, but it is not part of the eligibility disenrollment process. 9. Virginia doesn't prepare premium invoicing.

ME Disenroll Member

Disenroll Member		
Item	**Details**	**VA "As-Is" Details**
Shared Data	1. Benefit/Reference Information data store: Services and provider types covered; program policy; and health plan contractor information 2. Member Information data store: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Information data store: Contracted service areas, Managed Care Organization (MCO) provider network and other provider data 4. Provider Information data store: Provider data, such as type, location, availability, gender and linguistic and cultural competence	
Predecessor	■ **Determine Eligibility** ■ **Manage Applicant and Member Communication** ■ **Manage Contractor Communications** ■ **Manage Provider Communication**	
Successor	■ ***Manage Member Information*** ■ ***Manage Applicant and Member Communication*** ■ ***Manage Contractor Communications*** ■ ***Manage Provider Communication*** ■ ***Prepare Capitation Premium Payment*** ■ Care Management**, Establish Case** ■ Care Management**, Manage Case** ■ **Perform Population and Member Outreach** ■ **Manage Member Grievance and Appeal**	

ME Disenroll Member

Disenroll Member		
Item	**Details**	**VA "As-Is" Details**
Constraints	Programs have different termination criteria	The Medicaid, MCO, and FAMIS handbooks are on the Internet and available to the public. The MMIS benefit reports contain benefit package details. Medicaid and FAMIS references (handbooks under the "Client Services" section of the DMAS home page): http://www.dmas.virginia.gov/ Managed care references: http://www.dmas.virginia.gov/mc-home.htm MMIS benefit package reports are generated on demand by DMAS. Reports available: • RS-O-080, Benefit Package Enrollment Rules Report. Shows by benefit package, all the associated enrollment rules, its effective dates, its related values, and the values effective dates. • RS-O-090, Aid Category Eligibility Rules Report. Listed by aid category (A/C) showing data for the A/C, the benefit plans related to the A/C, and eligibility rules and rule values by relationship code for the A/C.

ME Disenroll Member

Disenroll Member		
Item	**Details**	**VA "As-Is" Details**
Failures	A member disenrollment process may fail at the following steps: 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. Disenrollment information is not loaded into Member Information data store 6. Successor processes do not receive or respond according to rules about disenrollment notification	
Performance Measures	1. Time to complete process: successful applicant is disenrolled within __ days 2. Accuracy of decisions 3. Consistency of decisions and disposition 4. Error rate is __% or less	

Disenroll Member: Business Capabilities

Dis-enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
General Description				
Is this business process primarily manual or automated?	The process is primarily manual. Disenrollment information is manually entered and automatically updates to the eligibility/ enrollment data store.	The process is a mix of manual and automated activities. Data may still be manually entered. Rules are automatically applied.	The process is primarily automated. Required data are delivered via MITA standard interface. Rules are configurable.	
Does this business process use standards?	Required data are entered into State-specific disenrollment forms. Rules are manually applied and verified.	Local standards based on HIPAA definitions are applied to the disenrollment process.	The process uses the MITA standard interface which is aligned with HIPAA and any other applicable standards.	
Does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	Each agency manages its own disenrollment process. Member data, including ID, demographics and health status is not comparable across programs, reducing ability to monitor program outcomes or detect fraud and abuse.	Information on disenrollment is shared among agencies. Members are disenrolled based on State business rules or Federal regulations. Members are also disenrolled from Waiver and Managed Care programs.	There is collaboration across the Medicaid enterprise on the exchange of disenrollment information.	
Va. As Is:		Agency focuses on cost management and improving the quality of and access to care within structures designed to manage costs. DMAS is engaged in		

Dis-enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		initiatives for disease state management, ALTC, PACE, PERM, and money follows the person.		
Va. To Be:		DMAS will continue to expand initiatives for disease state management, ALTC, PACE, PERM, and money follows the person.		
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	Disenrollments may take multiple business days.	Disenrollments are completed in 1 business day.	Turnaround time on disenrollment decision can be immediate. Average time to complete a disenrollment process is measured in seconds.	
Va. As Is:	Business process meets threshold or mandated requirements for timeliness. DMAS does make use of EDI and some automation.			
Va. To Be:	DMAS wants to increase automation and begin use of a Web portal/web services.			
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Disenrollment data and format are indeterminate. Disenrollment forms are not standardized and may be hard copy. Manual processes can adversely impact accuracy.	Disenrollment requests and exchange data use local versions of HIPAA standards, improving access and accuracy.	Disenrollment requests and exchange data use MITA standard interfaces, further improving access and accuracy to 90% or better.	

Dis-enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
How accessible is the information used in this process?	Information may be stored in disparate systems and may need to be accessed manually.	Data may be stored separately but can be accessed and aggregated as needed.	Data may be stored in either a single member registry or federated Enterprise member registries that can be accessed by all applications. Providers, members, and state enrollment staff have secure access to appropriate and accurate data on demand.	
Va. As Is:		Automation and standardization of business process is improving consistency and accuracy.		
Va. To Be:		DMAS wants to continue to improve consistency and accuracy and increase automation where applicable.		
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	Disenrollment occurs in silos without coordination, i.e., different processes and multiple pathways for each type of disenrollment. Considerable staff effort required to keep up with disenrollments within each month.	Cost-effectiveness improves with automation. The Disenroll Member process meets State cost containment guidelines.	Shared services, MITA standard interfaces, and inter-agency collaboration further improve cost-effectiveness over Level 2. The process demonstrates further improvement and value desired by the Medicaid enterprise.	
Va. As Is:	Process requires a sizeable			

Dis-enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	staff.			
Va. To Be:	DMAS will try to keep the staff size aligned with current and future workflow needs.			
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processes create inefficiencies.	Introduction of automation improves efficiency over Level 1.	Use of MITA standard interfaces further increases efficiency over Level 2.	
Va. As Is:	Most business processes are labor-intensive and "stovepiped". However, there are some automated areas.			
Va. To Be:	DMAS will continue to work towards full automation.			
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Decision making for the process is manual and therefore may result in inconsistent decisions. Complies with State guidelines for error rate.	Automation of business rules and standardization of disenrollment data improves accuracy of results. Decision making for the process is based on Medicaid enterprise policy which has been partially automated resulting in uniform decisions most of the time.	Adoption of MITA standard interface and Sharing of data with other agencies improves results. The process consistently applies business rules resulting in uniform decisions.	
Va. As Is:	Business process is labor-intensive, but results meet requirements for timeliness and accuracy.			
Va. To Be:	DMAS will work towards greater automation to			

Dis-enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	improve timeliness and accuracy.			
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.	
Va. As Is:	Business process complies with agency and state requirements.			
Va. To Be:	DMAS will move toward greater automation via MITA.			

ME Enroll Member

Enroll Member		
Item	**Details**	**VA "As-Is" Details**
Description	The ***Enroll Member*** business process receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible, loads the enrollment outcome data into the Member and Contractor data stores, 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. **NOTE:** There is a separate business process for disenroll member.	**{4}** Attachment A is missing {1} Also includes Medicaid Buy-in
Trigger Event	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.	
Result	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 into Member data store. 6. Notification to other eligibility systems.	

ME Enroll Member

Enroll Member		
Item	**Details**	**VA "As-Is" Details**
Business Process Steps	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. This step is conditional, as some States do no verification during enrollment process. Revert to determine eligibility process. 3. Verify that residence is appropriate for the enrollment. This step is conditional, as some States do no verification during enrollment process. Revert to determine eligibility process. 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 data store. 6. Notify other eligibility systems as appropriate. 7. Check for duplicate member. 8. End: Request that member and contractor be notified.	
Shared Data	1. Benefit data store: Services and provider types covered; program policy; and health plan contractor information. 2. Member data store: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded. 3. Contractor data store: Contracted service areas, MCO provider network and other provider data. 4. Provider data store: Provider data, such as type, location, availability, gender and linguistic and cultural competence. 5. GIS data.	5. Do not use GIS data (address/locality information only).
Predecessor	***Determine Eligibility*** process approves applicant as eligible for one or more program and benefit packages.	
Successor	1. ***Manage Applicant and Member Communication*** 2. ***Manage Contractor Communication*** 3. ***Outbound Transaction*** 4. ***Manage Member Information*** 5. ***Manage Provider Communication***	

ME Enroll Member

Enroll Member		
Item	**Details**	**VA "As-Is" Details**
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.	Handbooks under the "Client Services" section of the DMAS home page): http://www.dmas.virginia.gov/ Managed care references: http://www.dmas.virginia.gov/mc-home.htm
Failures	A member may fail to enroll in a specific program for the following reasons: 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.	
Performance Measures	1. Time to complete process: successful applicant is enrolled within __ days. 2. Accuracy of enrollment. 3. Consistency of enrollments and disposition. 4. Error rate is __% or less.	Performance measurement is difficult and varies widely.

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
Business Capability Descriptions **The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.**				
What Is the Access Channel for Receipt of Enrollment Application Form?	Applicants submit paper application forms to each program separately.	Application process is more automated. Some applications may be submitted on paper via. telephone or, web-based.	Applicants may initiate an eligibility/enrollment application online from home or a community location receive some responses in real time. Paper applications are still an option for those without computer access.	
What Is the Level of Collaboration with Other Programs?	There is no cross program coordination.	Staff collaborate within the agency.	Collaborating agencies use MITA standard interface for the enrollment data exchange. (“No Wrong Door”)	
Are Verification and Validation Activities manual or automated?	Approximately 20% of the verification and validation of enrollment data is performed automatically.	Approximately 50% or more of the verification and validation of enrollment data is automated; some information requires manual processing.	90% of the verification and validation of enrollment data is automated and is based on MITA HL7 data standards. Some categories of eligibility may be exceptions.	
How Are Business Rules Applied?	Enrollment policies, procedures, benefits and application forms are program specific and may be prone to error due to manual application of policies.	Some business rules are automated resulting in consistent application of these rules.	Maximizes number of automated business rules which accommodate business rules for multiple programs.	

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
Va. As Is:	Enrollment processes are paper-based and siloed within programs with no cross program coordination. Staff makes decisions autonomously and without consultation with other programs. Eligibility determination must precede enrollment and is done separately. Enrollment policies, procedures, benefits and application forms are program specific. Applicants must submit paper application forms to each program separately and responses may take several days. Process focus is on manually applying the agency's business rules to ensure that enrollment meets state and federal requirements. Staff manually verifies financial, socio-economic and health status information. Enrollment in managed care and waiver programs requires cumbersome extension of traditional fee-for-service processes.			

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
	Benefits cannot be "blended" across programs. Staff does not have the time or means to focus on meeting members' health, functional, cultural or linguistic needs. Staff must send paper enrollment notification to contractors. Some elements of Level 2 exist in the area of collaboration, coordination, and automation			
Va. To Be:	DMAS will expand its No Wrong Door initiative. Consumer directed services will also be expanding. For instance, a Money Follows the Person initiative is underway.			
BUSINESS CAPABILITY QUALITIES (Examples only excerpted from total list) [Qualities are capabilities that are measurable]				
Timeliness of Process				
What Is the Timeliness of End to End Process? Manual Process	From Mail Room In to Mail Room Out: Completion of the Enroll Member process is measured in months.	From Mail Room In to Mail Room Out: Completion of the Enroll Member process is measured in weeks	Manual processes are the exception and do not significantly impact performance of the business process.	
Electronic Process		From Electronic In to Out: No more than 14 days	From MITA Business Service Trigger to Result: timeliness improves over	

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
			Level 2	
Va. As Is:	Decisions on application may take several days; longer if verification of information is difficult. Contractors do not receive timely enrollment information. Some elements from level 2 are currently automated and the web is in use.			
Va. To Be:	DMAS will continue to work towards achieving Level Two.			
Data Access and Accuracy				
Are data and format standardized?	Enrollment data and format are non-standard	Enrollment data are standardized. Enrollment applications are standardized and electronic. Data can be used to support HIPAA transaction needs without crosswalking.	Enrollment and exchange data use MITA standard interfaces, improving accuracy, reusability, and interoperability.	
How accurate is the data?	Data accuracy is measured as sufficient to support operation of the business process	Data accuracy is noticeably improved over level 1.	Data accuracy is measured as 98% of total data stored and 98% of occurrences of data accessed.	
Va. As Is:	Enrollment data and format are indeterminate. Enrollment applications are not standardized and may still be			

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
	hard copy. Some enrollment records are stored electronically but storage is not centralized. Member data, including ID, demographics and health status, is not comparable across programs reducing ability to monitor program outcomes or detect fraud and abuse. Notifications to contractors are state-specific and differ by contractor type. Some elements of level 2 have been achieved (834 etc.)			
Va. To Be:	DMAS is working toward total automation and standardization of enrollment.			
Effort to Perform; Efficiency				
What Level of Effort is required?	The enrollment process required is labor intensive and inefficient due to manual processes.	The enrollment process requires less effort than at Level 1 due to increased efficiencies.	The enrollment process requires less effort than Level 2 due to increased efficiencies.	
Va. As Is:	Enrollment may occur in silos without coordination, i.e., different processes and multiple pathways for each			

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
	type of enrollment. Applicants and members can submit applications, make inquiries, and choose providers and MCOs on paper. Staff contact external and internal financial, socio-economic, demographic and health status verification sources via phone, fax. Some elements of level 2 exist relative to automation.			
Va. To Be:	DMAS wants to implement electronic transfer of requests to change benefit plan providers (MCO) as well as working on implementation of web-based application capabilities for: 1) Pre-Admission Screeners (due to be completed 12/31/07) 2) Nursing Facility Providers (to be able to complete on-line enrollments) 3) Hospice Providers (to be able to complete on-line enrollments).			

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
Cost-Effectiveness				
Is the cost of the enrollment process balanced by the results?	No. Siloed and manual enrollment processes are expensive and result in redundant effort and costs.	Fewer applicants and members are enrolled in the wrong program, reducing program costs and eliminating redundancy.	Shared services and inter-agency collaboration contribute to streamline the process.	
Va. As Is:	Requires a large staff to meet targets for manual enrollment of members. Siloed enrollment processes result in redundant infrastructure, effort and costs.			
Va. To Be:	DMAS wants to improve the processes using MITA standards.			
Accuracy of Process Results				
What are acceptable Error Rates?	Much of the application information is manually validated may be difficult resulting in increased error rates and potential for fraud. Decisions may be inconsistent.	Automation of data edits and business rules improves accuracy of validation and verification. Automated application of enrollment business rules improves consistency.	Use of MITA standard interface and automation of enrollment and verification data interchange improves consistency and accuracy of enrollment results. Error rate is 0.5% or higher.	
Va. As Is:	Much of the application information is manually validated and verification			

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
	may be difficult resulting in increase error rates and potential for fraud. Decisions may be inconsistent. Due to limited monitoring and re-verification of enrolled members' status, ineligible members may continue to be enrolled. MMIS and Contractor member registries are frequently not synchronized. Some elements of level 2 exist in the area of automation.			
Va. To Be:	DMAS will work towards Level Two.			
Stakeholder Satisfaction				
What is the level of stakeholder satisfaction?	Satisfaction level is described as adequate.	Satisfaction level is noticeably improved over level 1 and can be described as sufficient.	Satisfaction level is noticeably improved over level 2 and can be described as very good.	
Va. As Is:	Focus is on accurately processing enrollment and manually verifying information as efficiently as possible. Staff does not have time to focus on health,			

Enroll Member: Business Capabilities

Enroll Member				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Levels 4 & 5**
	functional, cultural and linguistic compatibility of provider or program for the member, or member satisfaction. Some elements of level 2 exist in the area of automation and coordination.			
Va. To Be:	DMAS will continue working towards Level Two.			

ME Inquire Member Eligibility

Inquire Member Eligibility		
Item	**Details**	**VA "As-Is" Details**
Description	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 receive covered services. **NOTE:** This process does not include Member requests for eligibility verification. Member initiated requests are handled by the ***Manage Applicant and Member Communication*** process.	3. DMAS also provides information on copays.
Trigger Event	Interaction-based Trigger Event: Receipt of Eligibility Verification Request data set from ***Receive Inbound Transaction*** process.	
Result	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.	
Business Process Steps	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 data store for requested information. 5. Process Response. 6. Log Response. 7. End: Prepare response data set for the ***Send Outbound Transaction*** process. **NOTE:** Security and Privacy verifications are handled by the Inbound, Outbound Transaction processes.	

ME Inquire Member Eligibility

Inquire Member Eligibility		
Item	**Details**	**VA "As-Is" Details**
Shared Data	1. Member data store: 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 (current version) and Batch Guide (current version).	
Predecessor	***Receive Inbound Transaction* Process**	
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	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. **NOTE:** Responses that a member is not eligible or is not active are not failures to process the request.	
Performance Measures	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. 4. CORE certified response.	1. Time to verify eligibility and generate response data set: e.g., Real Time response = within 05 seconds 97% of time, Batch Response = within _14_ hours of receipt of Trigger data set (processed overnight) 2. Response Accuracy = _100__% *3. Expected Error rate = _0_%*

Inquire Member Eligibility

Member Management: Inquire Member Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Business Capability Descriptions The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
In general, how acceptable is the eligibility verification process?	Process meets State guidelines but there are problems with timeliness and accuracy.	Automation greatly increases the ability to deliver timely and accurate eligibility information.	Use of MITA interface standards and the full range of X12 functionality increases the usefulness of this process.	
What formats are used for the eligibility request and response?	Inquiries about member's eligibility/enrollment in a program, coverage of benefits, etc. are received in non-standard formats. Media, data format and content differ by program	Eligibility Verification Requests and Responses are communicated using HIPAA X12 270/271 and NCPDP standards.	MITA standard interfaces incorporate full HIPAA data schemas and functionality.	
How collaborative is the inquiry process?	The sources of eligibility information are siloed within different programs; member data is not integrated and not semantically interoperable across programs. Therefore, inquirers must send inquiries to each agency.	Sources of eligibility begin to be integrated resulting in inquirers not having to send inquiries for multiple programs a member is eligible.	Agencies collaborate to establish a one stop shop eligibility inquiry process.	
What media are used to send and receive eligibility information?	Inquiries are sent via telephone, fax, and USPS.	Routine inquiries for member information are automated within the agency via AVRS, point of service devices, Web portal, EDI.	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.	
How consistent are eligibility inquiry responses?	Responses vary by individual responder. Level of consistency is moderate.	Automation greatly improves consistency of response. Level of consistency is good.	Using MITA standard interface data ensures increase in consistency of response. Level of consistency is high.	

Member Management: Inquire Member Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
How accurate are the responses to requests for eligibility verification?	Providers often depend on paper member ID cards that can be inaccurate.	Automation improves accuracy.	Use of MITA interface standards achieves maximum accuracy.	
Va. As Is:		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. The sources of eligibility information are siloed within different programs; member data is not integrated and not semantically interoperable across programs. Routine inquiries for member information are automated within the agency via AVRS, point of service devices, Web portal, EDI. Responses are immediate (online) and within batch (overnight). Responses are consistent, correct, and timely. Staff generally only needs to handle exceptions.		
Va. To Be:		DMAS hopes to provide a capability for members to verify their eligibility via AVRS, web portal, etc.. Currently DMAS supports these capabilities for providers but not for members.		
Business Capability Quality: Timeliness of Process				
How timely are responses to eligibility inquiry?	Most requests for verification of member	Member eligibility/ enrollment verification is	Using national standards for transport of request/	

Member Management: Inquire Member Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	information are received and responded to manually via phone, fax, USPS.	automated via AVRS, point of service devices, Web portal, EDI.	response and MITA standard interface and messaging, responses can be immediate. Response time is 30 seconds or less.	
How timely is the eligibility information?	Eligibility file is refreshed weekly.	Eligibility file is refreshed daily.	Eligibility file is real time.	
Va. As Is:		Member eligibility/enrollment verification is automated via AVRS, point of service devices, Web portal, EDI, but remains siloed. Responses can be immediate (online/real time) or batch (overnight for 270/271).		
Va. To Be:		DMAS hopes to provide a capability for members to verify their eligibility via AVRS, web portal, etc.. Currently DMAS supports these capabilities for providers but not for members.		
Business Capability Quality: Data Access and Accuracy				
How accurate are the responses to eligibility verification?	Information is researched manually. There may be inconsistencies in responses. Access and Accuracy is adequate to support the business process.	Automation improves access and accuracy. Access and Accuracy is noticeably improved over Level 1.	Member eligibility/ enrollment, program, and benefit data and messaging formats adhere to MITA standard interfaces, improving verification and research accuracy. Responses are accurate 99% of the time.	
Va. As Is:		Automation has improved access and accuracy. Access is via AVRS, point of service devices, Web portal, and EDI		

Member Management: Inquire Member Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		channels. Increased use of HIPAA eligibility/enrollment data (270/271). Minimal use of these transactions for COB.		
Va. To Be:		DMAS hopes to provide a capability for members to verify their eligibility via AVRS, web portal, etc.. Currently DMAS supports these capabilities for providers but not for members.		
Business Capability Quality: Cost-Effectiveness				
What is the ratio for the cost of eligibility verification versus the number of responses?	Generating ID cards for members monthly is expensive and cannot be guaranteed to block false claims of eligibility for service. 20% of the eligibility verifications result from human intervention; 80% of eligibility verifications are performed electronically without human intervention.	Electronic verification lowers cost to providers and State, and reduces denied claims for ineligible members and non-covered services. 10% of eligibility verifications result from human intervention; 90% are performed electronically without human intervention.	Use of MITA standard interfaces and full X12 functionality increase cost effectiveness by reducing staffing and increasing speed. 2% of eligibility verifications result from human intervention; 98% are performed electronically without human intervention.	
Va. As Is:		Automation has led to significant increases in the number of responses per day. However, the dental program uses an 834 and does not have real time transactions.		
Va. To Be:		DMAS hopes to provide a capability for members to verify their eligibility via AVRS, web portal, etc.. Currently DMAS supports		

Member Management: Inquire Member Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		these capabilities for providers but not for members.		
Business Capability Quality: Effort to Perform; Efficiency				
How do you rate the efficiency of the eligibility inquiry process?	Manual workflow is burdensome. Newly eligible members must wait to receive mailed ID cards or the provider must verify eligibility by telephone. Efficiency rating is low.	Automation increases efficiency. Efficiency is rated as adequate.	Use of national MITA standards and one stop shop among participating agency gives providers access to all cross-agency eligibility information including programs and benefits for which members are eligible. Efficiency rating is high.	
Va. As Is:		Responses to requests to verify member information are automated. Many providers are using the capabilities.		
Va. To Be:		DMAS hopes to provide a capability for members to verify their eligibility via AVRS, web portal, etc.. Currently DMAS supports these capabilities for providers but not for members.		
Business Capability Quality: Accuracy of Process Results				
What is the quality of the results of the Inquire Eligibility process?	Results quality is adequate.	Results are accurate and timely.	Results are accurate and timely 99% of the time and include eligibility for specific benefits and services.	
How is the quality of the result measured?	Responses are manually validated, e.g., call center audits; stakeholder satisfaction survey.	Automated processes include audit trails.	Business services standardize requests and responses nationally; tracking of response results is automatic.	
Va. As Is:		Automation improves accuracy of responses for providers only.		

Member Management: Inquire Member Eligibility: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Va. To Be:		DMAS hopes to provide a capability for members to verify their eligibility via AVRS, web portal, etc.. Currently DMAS supports these capabilities for providers but not for members.		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are stakeholders who have the authority to request eligibility verification?	Stakeholders are somewhat satisfied with results of inquiry.	Stakeholders have no delay in obtaining responses and are very satisfied.	Stakeholders have a one stop shop to access collaborating agencies to obtain information. Stakeholders experience fewer claim denials based on non-covered services. Providers are extremely satisfied.	
Va. As Is:		Providers have no delay (online/real time) in obtaining responses. Batch (270/271) responses are overnight.		
Va. To Be:		DMAS hopes to provide a capability for members to verify their eligibility via AVRS, web portal, etc.. Currently DMAS supports these capabilities for providers but not for members.		

ME Manage Applicant and Member Communication

Manage Applicant and Member Communication		
Item	**Details**	**VA "As-Is" Details**
Description	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. **NOTE:** Inquires from applicants, prospective and current members are handled by the ***Manage Applicant and Member Communication*** process by providing assistance and responses to *individuals*, i.e., 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 *Perform Applicant and Member Outreach* process targets both prospective and current Member *populations* for distribution of information about programs, policies, and health issues.	
Trigger Event	■ Interaction-based Trigger Events: – 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, requests for additional information, new eligible information packages, or determination decisions. – Includes inquiries originating from customer help desk ■ Event-based Trigger Events: – 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	

ME Manage Applicant and Member Communication

Manage Applicant and Member Communication		
Item	**Details**	**VA "As-Is" Details**
Result	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.	
Business Process Steps	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.]	2. DMAS doesn't have a central tracking mechanism for communication requests. 3. DMAS makes an effort to do this but it's not always consistent. 5. DMAS spot checks communication but the process could be inconsistent.
Shared Data	1. Benefit Data store: Services and provider types covered; program policy; and health plan contractor information 2. Member Data store: Member demographics, benefit package, eligibility/enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor Data store: Contracted service areas, MCO provider network and other provider data 4. Provider Data store: Provider data, such as type, location, availability, gender and linguistic and cultural competence 5. Service Directories such as Claims History, Prior Authorization, and Care Planning 6. Ancillary Communication Tracking Systems: Customer Relationship Management (CRM), Help Desk Log, PHI disclosure log, etc…	

ME Manage Applicant and Member Communication

Manage Applicant and Member Communication		
Item	**Details**	**VA "As-Is" Details**
Predecessor	1. ***Receive Inbound Transaction*** 2. ***Determine Eligibility*** 3. ***Manage Member Grievance and Appeal*** 4. ***Manage Population & Member Outreach***	
Successor	***Send Outbound Transaction*** process	
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.	{2}Eligibility isn't determined outside the agency. DMAS doesn't have presumptive eligibility.
Failures	1. Inability to provide linguistically, culturally, or competency appropriate information 2. Communication barriers such as lack of internet or phone access connectivity or unavailability of system; failure to access needed or requested information. This failure may occur on either the member or State side of the process. 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	4. Foster care communication and outreach is also challenging.
Performance Measures	Examples of Measures – 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 = ___%	DMAS has performance measures but they vary by business entity. Since DMAS doesn't have a central logging system, performance measures are difficult to track.

Manage Applicant and Member Communication: Business Capabilities

Member Management: Manage Applicant and Member Communication: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Business Capability Descriptions **The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.**				
What is the medium of communication?	Member communications are primarily conducted via paper and phone	Member communications are conducted via paper and phone; some electronic communication is available e.g., fax, scanned documents, uploads from the web portal, email.	Member communications are primarily electronic, with paper used only as needed to reach populations	
Is there intra-agency collaboration for communication?	Member and applicant communication is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target populations; of inconsistent quality; not always linguistically, culturally or competency appropriate.	States begin using Websites to provide member information on providers and health plans, and responses to inquires that can be responded to online or by phone General program information is available to applicants via websites.	Member and applicant 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	
Are standards used in communications?	No. Requests are received from members and applicants in non-standard formats	Member communications are linguistically, culturally, and competency appropriate, but require considerable manual intervention for paper communications	Yes. Standards ensure coordination and greater ability to measure the efficacy of member communications	

Member Management: Manage Applicant and Member Communication: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
How timely are the responses?	Most requests are sent via telephone, fax, or USPS; standard response within 2 days	Routine requests from members are standardized and automated within the agency via AVRS, Web portal	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	
Are responses timely, accurate?	Research is performed manually and responses are often inconsistent; delays are common	Research and response for these standardized communications are immediate or within batch response parameters; Responses are consistent and timely	Use of electronic communications makes provision of linguistically, culturally, and competency appropriate member communications more feasible and cost-effective Member Registries use standardized contact data, including USPS address standards, to alleviate postal delivery failures MITA standard interfaces (trigger event and results; messages to external entities), are used by Medicaid agency and collaborating sister agencies	

Member Management: Manage Applicant and Member Communication: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Va. As Is:	Member communications are primarily conducted via paper and phone. Member communications is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target populations; of inconsistent quality; not always linguistically, culturally or competency appropriate; may encounter obstacles to delivery, e.g., incorrect or lack of contact information. Requests are received from members in non-standard formats. Most requests are sent via telephone, fax, or USPS. Research is performed manually. Responses are inconsistent and manual. There may be delays in responses. Complies with agency goals and expectations. Requires signification labor force.	A number of level 2 automation elements exist. AVRS and/or web tools are not yet available to recipients	Level 3 "no-wrong door" initiative is being participated in with Dept of Aging., e.g. http://www.vda.virginia.gov/nowrongdoor.asp	
Va. To Be:	DMAS wants to fully implement Level Two (member/enrollee information access).			
Business Capability Quality: Timeliness of Process				

Member Management: Manage Applicant and Member Communication: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
What is the timeliness of the response?	Manual and semi-automated steps may require some days to complete response.	Member requests and responses are automated via Web, AVRS with date stamp and audit trail. Responses available on the average within 2 days	Member information is accessed via either a single Member Registry or federated Member Registries; Response is immediate; Inquiries can be made to multiple agencies via collaboration	
Va. As Is:	Manual and semi-automated steps may require some days to complete response. Some elements of Level Two exist (for providers only).			
Va. To Be:	DMAS wants to expand access to recipients to achieve Level Two. (member/enrollee information access).			
Business Capability Quality: Data Access and Accuracy				
What is accuracy of response?	Responses are made manually and there may be inconsistency and inaccuracy (within agency tolerance level).	Access is via Web portal; Automated responses increase accuracy	Requests and responses are standardized among Medicaids, improving accuracy	
Va. As Is:	Responses are made manually and there may be inconsistency and inaccuracy (within agency tolerance level). Some automation of Level Two exist.			
Va. To Be:	DMAS wants to expand			

Member Management: Manage Applicant and Member Communication: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	automated access to recipients to achieve Level Two (AVRS and Web).			
Business Capability Quality: Cost-Effectiveness				
Do the benefits of the operation justify the costs?	Requires numerous staff and high cost to meet demands of member communication	Improvements in member services and automation result in higher cost effectiveness than level 1.	Use of standards and collaboration and shared services further increases cost effectiveness.	
Va. As Is:	Requires research staff.			
Va. To Be:	DMAS wants to expand automated access to recipients (AVRS and web) to achieve Level Two.			
Business Capability Quality: Effort to Perform; Efficiency				
What level of effort is required to manage member communications?	Staff research and respond to requests manually.	Some responses to member requests are automated.	Collaboration among agencies achieves a one-stop shop for member inquiries; Information requested by member is continuously refreshed.	
Va. As Is:	Staff research and respond to requests manually.			
Va. To Be:	DMAS needs to implement automation to reach Level Two.			
Business Capability Quality: Accuracy of Process Results				
How accurate are the results of communications?	Responses are manually validated, e.g., via call center audits; member satisfaction survey.	Automation improves accuracy of responses.	MITA standard interfaces improve requests and responses nationally.	
Va. As Is:	Responses are manually validated, e.g., call center audits; member satisfaction survey. Process complies			

Member Management: Manage Applicant and Member Communication: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	with agency requirements.			
Va. To Be:	DMAS wants to expand automated access to recipients (AVRS and web) to achieve Level Two.			
Business Capability Quality: Utility or Value to Stakeholders				
Are stakeholders satisfied with responses?	Stakeholders receive information but there may be delays and inconsistent results.	Stakeholders have no delay in obtaining responses and information is accurate.	Stakeholders have a one stop shop to access collaborating agencies to obtain information.	
Va. As Is:	Members receive the information they need with some response delay.			
Va. To Be:				

ME Manage Member Grievance and Appeal

Manage Member Grievance and Appeal		
Item	**Details**	**VA "As-Is" Details**
Description	The ***Manage Member Grievance and Appeal*** business process handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the ***Manage Applicant and Member Communication*** process via the ***Receive Inbound Transaction*** process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file. The applicant or member is formally notified of the decision via the ***Send Outbound Transaction*** Process. This process supports the ***Program Quality Management*** Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. 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. **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.	1. DMAS primarily handles appeals for the Fee For Service program. The Managed Care Program handles both grievances and appeals. The MCO member can appeal to the MCO only, the MCO and DMAS simultaneously, or to DMAS instead of the MCO; at any time in the process, the member (Medicaid recipient) can waive the MCO process and request an appeal directly to DMAS. DMAS allows appeals to be expedited if they meet certain criteria. 2. Program Quality Management process is not supported on the Fee For Service side for Member appeals; however, the Fee For Service Provider appeal process does support the Program Quality Management process. The Managed Care Program supports the Program Quality Management process by including monitoring of enrollee grievances and appeals in the MCOs Quality Improvement Program (QIP). 3. The second appeal for the Fee For Service program goes directly to the circuit court, it is not handled internally by DMAS. If a Managed Care program appeal results in an unfavorable decision, the member can file an appeal with DMAS. The decision of the DMAS hearing officer is final is the final administrative ruling. It can be appealed to circuit court. 4. DMAS currently defines "grievance" and "appeal" differently. Grievances are only used by the Managed Care program.

ME Manage Member Grievance and Appeal

Manage Member Grievance and Appeal		
Item	**Details**	**VA "As-Is" Details**
Trigger Event	Receipt of grievance or appeal of adverse decision data set from ***Receive Inbound Transaction*** process.	Receipt of an appeal must be within 30 days of an adverse decision from a Fee For Service or Managed Care program member. Receipt of a grievance from a Managed Care member can be by phone in addition to the other stated methods, but must be followed up in writing.
Result	Final disposition of grievance or appeal sent to the applicant or member via the ***Send Outbound Transaction*** process.	The Fee For Service appeals business process steps differ somewhat from the MITA steps. For DMAS Step 4 in the MITA process occurs prior to Step 2. There is also an additional verification step that occurs after Step 1. Each appeal must be verified for timeliness, appealable action and that it was filed by the recipient or their authorized agent.
Business Process Steps	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. Schedule review or hearing within required time. 6. Conduct review or 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.	In the Fee For Service appeals process, additional information can be requested during and after the hearing as long as all parties are copied on the information requested.
Shared Data	1. Benefit data store: Services and provider types covered; program policy; and health plan contractor information 2. Member data store: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 3. Contractor data store: Contracted service areas, MCO provider network and other provider data 4. Provider data store: Provider data, such as type, location, availability, gender and linguistic and cultural competence 5. Policy data store: Based on the appeal process, if a member wins an appeal that could impact or clarify a policy, that information would be shared to a process that would change or modify policy and or the state plan,	

ME Manage Member Grievance and Appeal

Manage Member Grievance and Appeal		
Item	**Details**	**VA "As-Is" Details**
Predecessor	Receipt of grievance or appeal data set from ***Receive Inbound Transaction*** process.	
Successor	Formally notify applicant or member via ***Send Outbound Transaction*** process.	
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.	DMAS provides provisions for MCO enrollees that do not exist for Fee-for-service enrollees. MCO enrollees have a grievance process that is not available to fee-for-service members. As a result the grievance process may help to limit the number of appeals that are actually bought forward and provides an opportunity to resolve an issue at the lowest level before or instead of it becoming an appeal.
Failures	1. Applicant, member, or advocate withdraws grievance/appeal. 2. Grievances and appeals fail to be processed according to federal or state law.	Administrative cessation of appeals process within the confines of State and Federal laws.
Performance Measures	Examples of Measures – 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 = __%	Performance measures are to meet the stated time deadlines. Time to complete normal appeals - 90 days Time to complete expedited appeals - 72 hours. Accuracy and Consistency of decisions are not applicable to this process.

Manage Member Grievance and Appeal: Business Capabilities

Member Management: Manage Member Grievance and Appeal: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Business Capability Descriptions **The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.**				
What media are used to collect and store case documents?	This is an all-manual process. Grievances and appeals are filed via fax and USPS. Confidential documents are transferred by certified mail.	Documents are scanned and the case file is automated and can be shared among case workers.	MITA standard interfaces are used for Grievance and Appeal triggers (grievance and appeal application data) and results (case resolution).	
Are standards used in development of case documents?	No standards beyond general requirements for establishing a case.	Local documentation standardization is established.	MITA standard interfaces are used to initiate and develop the case, e.g., Request documentation; Validate credentials; Maintain case	
How are requests for additional documentation handled?	Requests for documents are managed manually.	Some review steps are automated using agency specific standards.	Case file is Web-enabled; information is shared among staff managing the case.	
How timely is the End to End process?	Indeterminate, lengthy	Time required to develop the case is reduced. Staff increased productivity by 50% from Level 1.	Additional streamlining of case process due to adoption of standard interfaces. Staff increased productivity by 50% from Level 2.	

Member Management: Manage Member Grievance and Appeal: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
How is case information verified?	Verification of information is handled manually. There may be inconsistencies between cases of the same type.	There is more consistency in the steps taken in the review and resolution process	Medicaid collaborates with other health and human services agencies that manage appeals to create a one-stop shop model for both member and consumer appeals, increasing accuracy of data by verifying multiple sources of information.	
Va. As Is:	This is mostly a manual process. Grievances and appeals are filed via fax and USPS. Fee For Service appeals can be hand delivered or received by e-mail. Managed Care grievances can be received via phone. Request for documentation and transfer of confidential documents can be done via fax and e-mail. Verification of information is handled manually. The process is lengthy. There may be inconsistencies between cases of the same type.	Documents are scanned and the case file is automated and can be shared among case workers. The appeals process for Prior Authorization, which is done by Keypro, is an automated process.		
Va. To Be:		As DMAS moves toward more automation, we would like for all documents to be scanned and filed electronically to reduce time and increase consistency of the process.		

Member Management: Manage Member Grievance and Appeal: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Business Capability Quality: Timeliness of Process				
What is the timeliness of the End to End (E2E) process? [Note: this measure does not include legal steps to stop the process.]	This is an all-manual process; Cases typically require months to complete. Duration of process is 180 business days or longer.	Automation in development of case file, scheduling hearings, storing documents results in reduction in E2E time. Duration of process is 100 business days or less.	Standardized MITA interfaces further streamline the E2E process. Duration of process is 45 business days or less.	
What is the timeliness of requests for information associated with the case?	Requests are dependent on telephone, fax, and mail service. May take weeks to receive information. Duration of request/ response is 20 business days or longer.	Requests for member information are automated via AVRS, Web portal, EDI within an agency. Duration is 10 business days or less.	Standard interface messages between the agency and the member or business associated are used. Responses to research questions are immediate across all data sharing partners within the state. Duration of process is 4 hours or less.	
Va. As Is:	This is a mostly manual process. Normal cases typically require months to complete.	Responses to research questions within the agency are immediate.		
Va. To Be:		DMAS would like to improve its timeliness and its use of automation.		
Business Capability Quality: Data Access and Accuracy				
How accurate are the case data?	Information is researched manually resulting in inconsistencies among	Automation of case files improves accuracy.	Standard MITA interfaces improve accuracy of content.	

Member Management: Manage Member Grievance and Appeal: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	case files; there are no standards for case data. It is difficult to measure accuracy.	Business rules are used to validate origin data. Case information is more accurate than Level 1. A standardized grievance definition is determined within State Medicaid e.g., eligibility, MCOs.	Case information is accurate 98% of the time.	
How accessible are case files (to authorized viewers)?	Requests are managed manually resulting in delays. Accessibility is rated as Poor	Access to available information is facilitated via Web portal and EDI channels using standard formats. Accessibility is rated as Good.	Access uses standard MITA interface and messaging. Accessibility is rated as Excellent	
Va. As Is:	Information is researched manually. There may be inconsistencies in responses. There are no standards for case data.	Prior Authorization appeals can be accessed over the Web.		
Va. To Be:		DMAS would like to improve access and accuracy by use of additional automation and standardizing the process.		
Business Capability Quality: Cost-Effectiveness				
What is the ratio of cost of operations to number of cases managed?	Process is labor-intensive.	Automation of some research steps increases productivity levels of staff required to manage caseloads.	Collaboration with sister agencies that may conduct parts of the appeals cases increases cost-effectiveness.	
Va. As Is:		DMAS uses an Oracle database and on-line screens to help manage		

Member Management: Manage Member Grievance and Appeal: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		cases.		
Va. To Be:		DMAS would like to standardize the use of automation to improve the cost-effectiveness by reducing staffing requirements to manage a case.		
Business Capability Quality: Effort to Perform; Efficiency				
What is the level of efficiency in this process?	Staff research and maintain manually. Highly inefficient due to manual processes.	Responses to requests to collect and verify member case information, and case management activities, are automated. Meets goals for efficiency improvements from Level 1.	Standardization of input and case results allows staff to focus on analytical activities. MITA standard interfaces standards are used for creation of a case, acquisition of information, and publication of results. Improved efficiency from Level 2 processes.	
Va. As Is:	Staff research and maintain manually.	DMAS uses an Oracle database and on-line screens to help manage cases.		
Va. To Be:		DMAS would like to standardize the use of automation to improve efficiency of the process.		
Business Capability Quality: Accuracy of Process Results				
What is the level of accuracy in the case results?	There may be inconsistencies in results between similar cases.	Results are documented and recorded automatically and can be accessed and reviewed as needed.	MITA standard interface improves accuracy of case results.	
Va. As Is:	For the Managed Care	The Oracle database used		

Member Management: Manage Member Grievance and Appeal: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	grievance process, terms of the settlement or results of the hearing are manually documented according to the administrative rules of the state. There may be inconsistencies between similar cases. Process complies with agency requirements.	by DMAS to help manage case; calculates time tables for the processes and tracks the process over time.		
Va. To Be:		DMAS would like to standardize the use of automation to improve the accuracy of results.		
Business Capability Quality: Utility or Value to Stakeholders				
What is the degree of satisfaction to the member regarding the process? [Note: does not ask about satisfaction with the Result]	Low level of satisfaction due to demands of and delays in the process.	State has determined standardized measurement improving member access, communication, and implementation of the grievance and appeal process. The member benefits from introduction of automation to speed up the case resolution. Satisfaction level is higher than Level 1	Members benefit from consistency and predictability of the process. Satisfaction level is higher than Level 2	
What is the degree of satisfaction to stakeholders?	Business process complies with agency and state requirements for a fair hearing and disposition. However, stakeholders are not	The agency benefits from introduction of automation to speed up the case resolution. Stakeholders are satisfied.	Agencies benefit from introduction of MITA standard interfaces. Stakeholders are very satisfied.	

Member Management: Manage Member Grievance and Appeal: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	satisfied with the burden of research and delays.			
Va. As Is:	Business process complies with agency and state requirements for a fair hearing and disposition.	The automated process for Prior Authorizations appeals has greatly benefited the members.		
Va. To Be:		DMAS wants to standardize the use of automation to benefit both the members and the agency with faster and more consistent results.		

ME Manage Member Information

Manage Member Information		
Item	**Details**	**VA "As-Is" Details**
Description	The ***Manage Member Information*** business process is responsible for managing all operational aspects of the Member data store, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid. The Member data store is the Medicaid enterprise "source of truth" for member demographic, financial, socio-economic, and health status information. A member's data store record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services. In addition, the Member data store 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. The Member data store may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend-down information. Business processes that generate applicant or member information send requests to the Member data store to add, delete, or change this information in data store records. The Member data store validates data upload requests, applies instructions, and tracks activity. The Member data store provides access to member records, e.g., for Medicare Crossover claims processing and responses to queries, e.g., for eligibility verification, and "publish and subscribe" services for business processes that track member eligibility, e.g., ***Manage Case*** and ***Perform Applicant and Member Outreach***.	2, 4 & 5. DMAS does not have a central registry/"source of truth". Currently, users must search for the information.

ME Manage Member Information

Manage Member Information		
Item	**Details**	**VA "As-Is" Details**
Trigger Event	■ State transition trigger event: Receipt of request to add, delete, change Member information or pointers to member information records from – 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 data store'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, member out-of-pocket co pay/coinsurance, HIPP, and service authorization), **Calculate Spend-down**, or **Process Member Premium Invoice** – Care and Program Integrity Management Manage data store 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.	

ME Manage Member Information

Manage Member Information		
Item	**Details**	**VA "As-Is" Details**
Result	The Member data store is loaded with new or updated member information for the purposes of: 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 5. Supplying all Care Management Area business processes with applicant or member information needed to e.g. create or update care plans. 6. Supplying data to Program Integrity business proceses.	
Business Process Steps	1. Start: Receives data from Member Management Area and relevant Operations Management business processes 2. Loads data into the Member data store, 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	

ME Manage Member Information

Manage Member Information		
Item	**Details**	**VA "As-Is" Details**
Shared Data	The **Manage Member Information** business process accesses Shared 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, data necessary for care management business processes.	
Predecessor	Inbound Transaction Processing for eligibility and enrollment applications, communications, scheduling requests. Member Management business processes supplying data to the Member data store, including **Determine Eligibility**, **Enroll Member, Disenroll Member, Perform Population and Member Outreach, Manage Applicant and Member Communication, and Manage Member Grievance and Appeal.** Operations Management business processes supplying data to the Member data store e.g., **Calculate Spend-down Amount,** and **Prepare Member Premium Invoice** business processes. Care Management business processes supplying data to the Member data store, e.g., **Authorize Treatment Plan**	

ME Manage Member Information

Manage Member Information		
Item	**Details**	**VA "As-Is" Details**
Successor	There are two types of Successor Business Processes: a) those that are the director successor, i.e., the Result of Manage Member Information is a Trigger for another business process, and b) those that are indirect successors business processes that are consumers of Member information as Shared Data. <u>Direct Successor Business Processes</u> 1. Member Management – **Enroll Member, Disenroll Member** 2. Care Management – **Establish Case** 3. Program Integrity – **Identify Candidate Case** <u>Indirect Successor Business Processes</u> Many business processes are dependent on current and accurate member information. These processes access the Member data store. 1. Member Management business processes accessing data in the Member data store, including **Determine Eligibility**, **Perform Population and Member Outreach**, **Manage Applicant and Member Communication**, and **Manage Member Grievance and Appeal**. 2. Operations Management Area business processes, including: **Edit Claim-Encounter**, **Audit Claim-Encounter**, **Prepare Health Insurance Premium Payment**, **Prepare Medicare Premium Payment** and **Prepare Capitation Premium Payment** business processes; **Process Member Premium Invoice**, **Prepare EOB**, and **Calculate Spend-down** business processes; and all Cost Recovery business processes. 3. Care Management Business Area: **Manage Case** business processes. 4. **Manage Program Information** business process. 5. Program Integrity **Manage Case** business processes.	
Constraints	State specific work flows will determine which processes load and access the Member data store and by which interactions and messages (e.g., query/response, batch uploads, publish and subscribe, etc.); and the data content and structure of data store records.	

ME Manage Member Information

Manage Member Information		
Item	**Details**	**VA "As-Is" Details**
Failures	Member data store fails to load or update appropriately; or fails to make data store data available or available in correct format.	
Performance Measures	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	DMAS has some performance measures but they are inconsistent and vary by program.

Manage Member Information

Member Management: Manage Member Information: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Business Capability Descriptions The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.				
Does the process meet or exceed legal, regulatory, or agency requirements or expectations?	At this level, the Manage Member Information business process meets the needs of the FFS Medicaid program and MMIS certification requirements such as MARS and MSIS reporting and is validated via OIG reports, staffing and error reports	At this level, the Manage Member Information business process meets the needs of programs beyond FFS and continues to be validated by external measures	At this level, the Manage Member Information business process improves and benefits from member-centric, No Wrong Door initiatives, and will include things such as rules engines to enhance accuracy. Validation to external measures is automated.	
How do you handle updates of member information from different sources?	There are delays loading data generated from multiple sources and supplied by multiple media including hand delivery	Updates are automated; paper or hand-delivered files are the exception	Updates are fully automated with triggers from multiple sources.	
Can duplicate entries be detected?	Duplicate entries may go undetected	Better internal controls improve level of identification of duplicates	Use of national (ex:HL7) standards and vocabulary for entity identification improves ability to detect and handle duplicates	
Are eligible update notifications sent to stakeholders?	Irregular update notification to interested users and processes	Notification to interested users and processes is immediate (as soon as update occurs)	Standardized update notifications to stakeholders adheres with service level agreements and are sent	

Member Management: Manage Member Information: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
			via preferred communication method.	
Do you perform daily eligibility updates?	Legacy member files, lack of integration with the eligibility system, and mailing paper IDs limit Agencies to monthly eligibility periods vs. day-based eligibility/enrollment	Integration with eligibility system supports day based eligibility/enrollment	Daily eligibility updates are available in real time at point of service.	
Are there standard formats for updates?	Data updates are received from disparate sources in indeterminate formats	Data updates are standardized; requested and scheduled data extraction is increasingly automated	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	
Are the data updates accurate?	Validation of data is inconsistent and not rules-based	Rule-based validation and data reconciliation is more consistent and improves integrity of data repository	Standard interfaces (trigger event and results; messages to external entities), standardized data, consistent business rules and decisions, easy to change business logic	
Is there an audit trail for updates?	Updates are inconsistently tracked	Updates are automated with date stamp and audit trail	Manage Member Information is handled by a business service with built-in tracking	
Va. As Is:	At this level, the Manage Member Information business process is designed to serve FFS Medicaid programs and meet MMIS certification requirements such as	DMAS has level 2 rule-based validation and automated data reconciliation processes	Level 3 "no-wrong door" initiative is being participated in with Dept of Aging., e.g. http://www.vda.virginia.gov/nowrongdoor.as	

Member Management: Manage Member Information: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	MARS and MSIS reporting. Data requests are received from disparate sources in indeterminate formats. Data is shared in batch on a scheduled or ad hoc basis. Validation is inconsistent and not rules-based. There are delays in completing updates and loading member data generated from multiple sources. Duplicate entries may go undetected. Irregular update notification to interested users and processes. Legacy member files, lack of integration with the FAMIS and mailing paper ids may limit Agencies to monthly eligibility periods vs. day based eligibility/enrollment.		p	
Va. To Be:				
Business Capability Quality: Timeliness of Process				
How timely are the member updates?	Manual and semi-automated steps delay updates; updates take from one week to one month	Update schedule improves over Level 1. On the average, updates occur daily (within 24 hours)	Updates and data extractions can be immediate	
How timely are the notifications regarding updates?	Notifications are inconsistent in regards to time, and in general, are not timely, i.e., 5 or more days later than the update	Timelier member updates and data extractions; available on the day of the update	Data exchange partners receive update notifications instantly	
Va. As Is:	Manual and semi-automated steps delay updates, maintenance processes and			

Member Management: Manage Member Information: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	require system down-time. Inadequate audit trails.			
Va. To Be:	Need something practical for users to access and research audit trails.			
Business Capability Quality: Data Access and Accuracy				
How accurate are the updates?	Updates are made to individual files manually. Manual updates result in inconsistency and mistakes.	Automated updates are made to individual files and databases. Applied edits reduce inaccuracy.	Updates, notifications, and data extractions (e.g., MSIS eligibility reports and MCO enrollment rosters) are standardized	
How are records stored?	Data stores may be multiple; there are issues of duplicate identifiers, discrepancies between data stores, and information quality and completeness	Databases may be relational	Member records are stored in either a single Member Registry or federated Member Registries that can be accessed by all authorized applications	
Va. As Is:	Automated updates are made to files and relational databases. However, problems with Data issues: duplicate identifiers, discrepancies between data stores, and information quality and completeness exist.			
Va. To Be:				
Business Capability Quality: Cost-Effectiveness				
What is the ratio of level of effort to results achieved?	Requires numerous data entry staff to key new and updated information, and	Automation leads to greater productivity and cost effectiveness than at level	Distributed update notifications to federated member registries further	

Member Management: Manage Member Information: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	reconcile duplicates and data inconsistencies; IT staff needed to load member information generated from other systems	1.	increases productivity and cost effectiveness over level 2. .	
Va. As Is:	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.			
Va. To Be:				
Business Capability Quality: Effort to Perform; Efficiency				
What is the level of efficiency for this process?	Numerous staff required to support mostly manual processes. Staff must key new information; make updates manually; reconcile and validate data manually.	Automation results in improved process efficiency over level 1. Updates are automatically processed	Standardization adds to level of efficiency greater than level 2. Updates are distributed to data sharing partners immediately.	
Va. As Is:	Staff must key new information; make updates manually; reconcile and validate data manually. 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.			

Member Management: Manage Member Information: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	DMAS does process updates automatically and edits are consistent.			
Va. To Be:				
Business Capability Quality: Accuracy of Process Results				
Are the member update results consistent, accurate, and useful to users?	Member information is maintained and available, primarily on a scheduled or request basis to other business processes and users	Automated maintenance of member information ensures that timely, accurate data are available to support all processes needing member information	Use of national standards support federated access to data; business rules and standards result in high level of accuracy	
Va. As Is:	Updates and reconciliations must be manually validated. Process focus is on compliance with agency requirements and less on ensuring timely availability of quality/complete data for users.	DMAS has elements of level 2; automation and reconciliation of database updates.		
Va. To Be:				
Business Capability Quality: Utility or Value to Stakeholders				
What is the level of satisfaction of stakeholders regarding the Member Information update process?	Updates and reconciliations must be manually validated. Stakeholder satisfaction with results is low.	Automation improves accuracy of validation, verification, and reconciliation of database updates. Stakeholder satisfaction improves	Stakeholder satisfaction improves because data accessibility increases the efficiency, speed, and accuracy of member information management processes.	
Va. As Is:		Automated maintenance of member information ensures that timely, accurate data are available to support all		

Member Management: Manage Member Information: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		processes needing member information, e.g., MCO enrollment rosters, COB, adjudication, etc. However, Data is not available at all times or in an easily accessible manner for all processes.		
Va. To Be:		DMAS wants to work on improving the availability and accessibility of data.		

ME Perform Population and Member Outreach

Perform Population and Member Outreach		
Item	**Details**	**VA "As-Is" Details**
Description	The ***Perform Population and Member Outreach*** business process originates internally within the Agency for purposes such as: – Notifying prospective applicants and current members about new benefit packages and population health initiatives – New initiatives from Program Administration – Receiving indicators on underserved populations from the ***Monitor Performance and Business Activity*** process (Program Management) It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children's Health Insurance Program (SCHIP). 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*** processes. 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. **NOTE:** The ***Perform Population and Member Outreach*** process targets both prospective and current Member *populations* for distribution of information about programs, policies, and health issues. Inquires from applicants, prospective and current members are handled by the ***Manage Applicant and Member Communication*** process by providing assistance and responses to *individuals*, i.e., bi-directional communication.	

ME Perform Population and Member Outreach

Perform Population and Member Outreach		
Item	**Details**	**VA "As-Is" Details**
Trigger Event	State-transition Trigger Events: – 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 targeted population – Identification of underserved and currently served populations in need of services or access Other healthcare or Federal mandates (e.g., Privacy notice)	
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.	
Business Process Steps	1. Start: 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 or 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 through various mediums supported by the ***Send Outbound Transaction, Manage Applicant and Member Communication***, or the ***Manage Business Relationship Communications*** process (to be distributed to targeted populations by community resource and advocacy groups, providers, and other entities that work with the targeted population) 7. Outreach communications production and distribution are tracked and materials archived [Steps may differ in a State-wide managed care setting.]	

ME Perform Population and Member Outreach

Perform Population and Member Outreach		
Item	**Details**	**VA "As-Is" Details**
Shared Data	1. Care Management population health data 2. Program Quality Management quality measure data, e.g., CAPHS and HEDIS measures 3. Benefit data store: Services and provider types covered; program policy; and health plan contractor information 4. Member data store: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded 5. Contractor data store: Contracted service areas, MCO provider network and other provider data 6. Provider data store: Provider data, such as type, location, availability, gender, linguistic qualifications and cultural competence. 7. Claims history	
Predecessor	Care Management, Benefit Administration, Program Administration, or Program Quality Management processes result in need to perform outreach to prospective members	
Successor	1. ***Send Outbound Transaction***, ***Manage Applicant and Member Communication*** and/or ***Manage Business Relationship Communication*** processes distribute communications to the targeted population 2. ***Monitor Performance and Business Activity Process*** measures Outreach efficacy	
Constraints	Communications and information packages must address the needs of the targeted 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.	
Failures	1. Inability to produce information that is useable due to language, culture, or reading comprehension barriers 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	3. Foster care communication and outreach is also challenging.

ME Perform Population and Member Outreach

Perform Population and Member Outreach		
Item	**Details**	**VA "As-Is" Details**
Performance Measures	Examples of Measures – 1. Time to complete process of developing outreach materials from receipt of request to completion of distribution = __ days 2. Accuracy of outreach materials = __% 3. Successful delivery rate to targeted individuals = ___% 4. Combination of staff plus automated processes results in utilization of _____FTEs per occurrence of this process.	DMAS has performance measures but they vary by business entity. Since DMAS doesn't have a central logging system, performance measures are difficult to track.

Perform Population and Member Outreach: Business Capabilities

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Business Capability Descriptions **The Section provides general background on the Business Process at Level 1 – 3. It is used to identify the differences between Levels.**				
Does the State Medicaid agency coordinate outreach to the general population and Medicaid eligibles in a coordinated, efficient, and timely way that meets result expectations?	At this level, the Perform Applicant and Member Outreach business process is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes or is non-existent.	At this level, the Perform Applicant and Member Outreach business process is more coordinated and populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socioeconomic status, functional and health needs based on increased standardization of administrative data, and improved data manipulation for decision support.	At this level, the Perform Applicant and Member Outreach business process is organized around the no wrong door concept, which ensures that regardless of outreach campaign, current and prospective members will be able to access information about all programs that member may be eligible to receive.	
Va. As Is:		At this level, the Perform Applicant and Member Outreach business process is 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 and health needs based on increased standardization of administrative data, and improved data manipulation for		

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		decision support. In addition to phone and paper, states use Websites, Agencies use TV, radio and advertisements to distribute outreach information to targeted members. Outreach material is functionally, linguistically, culturally, and competency appropriate, but at great expense. 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 needed information.		
Va. To Be:		DMAS desires to move towards achieving Level Three as MITA standards become available.		
How do you rate the quality and consistency of outreach activities?	Quality and consistency of outreach and education efforts are difficult to measure.	Better demographic data helps agency target populations and measure results.	Use of standards and inter-agency collaboration improves quality and consistency.	
Va. As Is:				
Va. To Be:				
Do outreach materials reach targeted audience?	The agency may encounter obstacles to delivery, e.g., incorrect	Better data are available to connect with targeted populations.	Outreach and education materials are targeted more effectively due to	

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	address or lack of contact information.		improved data availability. Materials are available via web portals and are shared with other collaborating agencies; Member registries use standardized contact data, including USPS address standards, to alleviate postal delivery failures.	
Va. As Is:				
Va. To Be:				
Can stakeholders easily access information about programs?	Current and prospective members have difficulty locating needed information because of siloed programs.	Help lines and public advertising reaches a broader population.	Current and prospective members are easily able to access information regardless of their channel of inquiry or the program about which they need information. (No Wrong Door)	
Va. As Is:				
Va. To Be:				
Do you address the needs of populations that have functional, linguistic, cultural, and competency challenges?	Functionally, linguistically, culturally, and competency appropriate outreach and education materials are lacking because they are difficult and costly to produce.	Outreach material is functionally, linguistically, culturally, and competency appropriate, but at great expense, or may be limited by State defined parameters (ex: only two languages used).	Use of electronic communications makes provision of functionally, linguistically, culturally, and competency appropriate outreach material more cost-effective.	
Va. As Is:				
Va. To Be:				

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
How efficient are the outreach operations?	Outreach is primarily manual and conducted by paper or phone.	In addition to phone and paper, states may use Websites, TV, radio and advertisements to distribute outreach information to targeted members.	Better collaboration and standards ensures agency-wide outreach coordination and greater ability to measure the efficacy of outreach and the percentage of targeted populations reached. 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.	
Va. As Is:				
Va. To Be:				
What is the basis for the outreach approach?	Outreach to prospective members is sporadic and lacks analysis needed for targeting populations based on demographics, socioeconomic status, functional and health needs.	Access to improved demographic data supports more targeted outreach.	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.	
Va. As Is:				

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Va. To Be:				
Business Capability Quality: Timeliness of Process				
How timely are the outreach activities	From end to end, outreach mailings take 3 or more months to produce and send.	Educational materials are distributed, end to end, in 1 to 2 weeks in a combination of written and electronic formats.	Outreach and education information are immediately available to members and the general population via agency portals.	
Va. As Is:		Electronic storage and dissemination of member materials shortens the time to reach the members. Paper and non-routine outreach is still time-consuming. Access to electronic sources or outreach and education materials somewhat reduces time that current and prospective members must spend discovering needed information.		
Va. To Be:		DMAS desires to move towards achieving Level Three as MITA standards become available.		
Business Capability Quality: Data Access and Accuracy				
What is accuracy of mailing information?	Mailings are not delivered because contact data in members records do not meet USPS standards.	Increased adoption of USPS standards automated mail merges increases accuracy of mailings.	Exclusive use of USPS standards and automated addressing for member data improves accuracy for mailing purposes.	
Va. As Is:		Automation improves access		

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		and accuracy. Current and prospective members can access needed information via Web portal. Increased standardization of administrative data, and improved data manipulation for decision support improves accuracy of population targeting. Increasing use of functionally, linguistically, culturally, and competency appropriate outreach and education materials improve members' access to information.		
Va. To Be:		DMAS desires to move towards achieving Level Three as MITA standards become available.		
What is accuracy of content information?	Preparation of materials is manual and subject to error; Information is subject to inaccuracies and inconsistencies.	Increasing use of functionally, linguistically, culturally, and competency appropriate outreach and education materials improves content accuracy.	Use of standardized data to create messages improves accuracy.	
Va. As Is:				
Va. To Be:				
What is accuracy of population and member targeting?	Some ability to target members with certain diagnoses; very difficult to target other populations.	Increased standardization of administrative data, and improved data manipulation for decision support improves accuracy of population targeting.	Standards enhance ability to target populations; Member information is accessed via federated Member Registries that can be accessed by all authorized entities within	

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
			the state.	
Va. As Is:				
Va. To Be:				
How easy is access to the outreach material?	Lack of outreach and education materials likely limit members access to information.	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 member's ability to locate needed information.	Current and prospective members are easily able to access information regardless of their channel of inquiry or the program about which they need information. (No Wrong Door)	
Va. As Is:				
Va. To Be:				
Business Capability Quality: Cost-Effectiveness				
How cost effective is the outreach process?	Process is labor-intensive; high costs reduce frequency of outreach.	Automation results in proficiency in targeting populations needing outreach and education.	Collaboration, data sharing, and shared services increase cost-effectiveness.	
Va. As Is:		Automation reduces level of staffing required to target populations needing outreach and education. Availability of online materials reduces paper and mailing costs.		
Va. To Be:		DMAS desires to move towards achieving Level Three as MITA standards become available.		
How cost effective is the media used?	Paper materials are expensive to produce and	Availability of online materials reduces paper	Predominant use of electronic and public	

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	incur postal expenses and cost of undelivered mail.	and mailing costs Part of the cost is achieving the outcome and these measures are not addressing the outcome of the process. It is not cost effective if people can't read and access it or not actually receiving the data. Need to define and measure effectiveness that web is more efficient.	media communication channels lowers cost of paper materials and improves message delivery; USPS standard member contact information decreases undelivered mailings.	
Va. As Is:				
Va. To Be:				
Business Capability Quality: Effort to Perform; Efficiency				
What is the degree of efficiency in the creation of the outreach materials?	Staff develops and maintains materials manually; this is a labor intensive operation.	Populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socioeconomic status, functional and health needs based on increased standardization of administrative data, and improved data manipulation for decision support.	National standards are developed for creation of education and outreach materials. Evidence-based medicine guidelines are used in targeting.	
Va. As Is:		Populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socio-		

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		economic status, functional and health needs based on increased standardization of administrative data, and improved data manipulation for decision support. Materials can be posted on a Web site for downloading by members. Fewer staff required to support. Delivery of functionally, linguistically, culturally, and competency appropriate outreach and education materials is eased with electronic and public media channels.		
Va. To Be:		DMAS desires to move towards achieving Level Three as MITA standards become available.		
How efficient is the ability to target populations?	Considerable effort is required to research current and target prospective populations and track mailings.	Better demographics captured in member data stores and external databases, improves ability to target over level 1.	Business services are developed and shared nationally to support target population identification.	
Va. As Is:				
Va. To Be:				
How efficient are distributions to targeted populations?	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.	Mailings are more accurate, transitioning to electronic distribution.	Mailings are now the exception. Electronic distribution is efficient and accurate.	

Member Management: Perform Population and Member Outreach: Business Capabilities				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
Va. As Is:				
Va. To Be:				
Business Capability Quality: Accuracy of Process Results				
How accurate are the outreach results? [i.e., does the outreach reach the intended audience and is it read?	Current measures do not accurately reflect outreach results.	Automated tracking yields some statistics. Use of portal by members is monitored to ensure that a sufficient number of the targeted populations are actively engaged in downloading information.	Automated tracking and surveys provide accurate feedback regarding accuracy of outreach.	
Va. As Is:	Difficult to determine impact of outreach and education. Current and prospective members continue to need assistance by phone.			
Va. To Be:	DMAS wants to expand access to recipients (AVRS/Web) to achieve Level Two.			
Business Capability Quality: Utility or Value to Stakeholders				
Do the efforts reach the targeted population and result in stakeholder satisfaction?	Difficult to measure.	Better tracking and feedback processes over level 1 result in better measurements; stakeholders are found to be generally satisfied.	Member satisfaction is collected as part of the process and shows improvements over Level 2.	
Va. As Is:		The members and the agency benefit from introduction of automation to speed up the outreach and education process.		
Va. To Be:				

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(BR) Business Relationship Management										
(ME) Member Management										
ME Determine Eligibility	**Description:** Receives application data, checks for status, establishes type of eligibility, verifies applicant information, assigns identifiers, associates with benefit packages, and notifications.									
	2010 MITA: **To Be:** Virginia wants to continue to pursue Level 2 and above in the maturity model. Virginia will expand its No Wrong Door initiative. Consumer directed services will also be expanding. For instance, a Money Follows the Person is complete. Virginia is moving toward a citizen centric portal, a business rules engine and work flow engine. **2007 MITA:** **To Be:** DMAS will expand its No Wrong Door initiative. Consumer directed services will also be expanding. For instance, a Money Follows the Person initiative is underway. **Other:** The "no wrong" door is a broad topic area and various initiatives are underway (transformation grants) with others in discussion. Specific time frames cannot be determined at this time as enabling technology is needed. Requests and priorities are also impacted by Federal, Governor and State Secretariat Initiatives in these areas.	1	1						**X**	

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
ME Disenroll Member	**Description:** Termination of a members (recipient) enrollment; notification to member and other related communication/outreach.									
	2010 MITA: **To Be:** Virginia's desire is to work toward level 3. Virginia will pursue the citizen portal for applicants to enter their own information to be considered for services. VA will be automating a Business Rules Engine as well as a Workflow Engine. Virginia will continue to work towards full automation. **2007 MITA:** **To Be:** DMAS will continue to expand initiatives for disease state management, ALTC, PACE, PERM, and money follows the person. DMAS wants to increase automation and begin use of a Web portal/web services. **Other:** The "no wrong" door is a broad topic area and various initiatives are underway (transformation grants) with others in discussion. Specific time frames cannot be determined at this time as enabling technology is needed. Requests and priorities are also impacted by Federal, Governor and State Secretariat Initiatives in these areas.	1	1						**X**	
ME Enroll Member	**Description:** Determines additional qualifications for enrollment (MC, HIPP, Waiver etc.) Stores data and produces notifications to member and contractor.									

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010 MITA: **To Be:** Virginia is moving toward a citizen centric portal, a business rules engine and work flows that will take it to a level 3. Virginia is working on a rules engine that will help take it to level 3. **2007 MITA:** **To Be:** DMAS will expand its No Wrong Door initiative. Consumer directed services will also be expanding. For instance, a Money Follows the Person initiative is underway. DMAS wants to implement electronic transfer of requests to change benefit plan providers (MCO) as well as working on implementation of web-based application capabilities for: 1) Pre-Admission Screeners (due to be completed 12/31/07); 2) Nursing Facility Providers (to be able to complete on-line	1	1						**X**	
ME Inquire Member Eligibility	**Description:** Inquiries for eligibility verification from providers, programs, or business associates.									

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010 MITA: **To Be:** Virginia is updating to 5010 and will work toward achieving level 3. Virginia will work toward fully meeting level 3 criteria. Virginia hopes to provide eligibility for other programs. Virginia will work toward level 3 by continuing to improve the audit trail and improve automation with MITA standards. **2007 MITA:** **To Be:** DMAS hopes to provide a capability for members to verify their eligibility via AVRS, web portal, etc. Currently DMAS supports these capabilities for providers but not for members.	2	2			**X**				
ME Manage Applicant and Member Communication	**Description:** Requests for information, appointments, and assistance from prospective and current members (help desk etc.).									

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010 MITA: To Be: Virginia expects to reach level 3 with the implementation of the citizen centric portal. Virginia hopes to work toward level 3 with the citizen centric portal. Virginia wants to expand automated access to recipients (AVRS and web) to achieve Level Two. **2007 MITA:** **To Be:** DMAS wants to expand automated access to recipients to achieve Level Two (AVRS and Web).	1	2			**X**				
ME Manage Member Grievance and Appeal	**Description:** Addresses applicant/member (or advocates) appeals of adverse decisions or communications of a grievance.									

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010 MITA: **To Be:** As Virginia moves toward more automation, we would like for all documents to be scanned and filed electronically to reduce time and increase consistency of the process. DMAS wants to standardize the use of automation to benefit both the members and the agency with faster and more consistent results. **2007 MITA:** **To Be:** As DMAS moves toward more automation, we would like for all documents to be scanned and filed electronically to reduce time and increase consistency of the process.	1	2					**X**		
ME Manage Member Information	**Description:** Managing and maintaining enrollment records and data.									

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010 MITA: **To Be:** Working to fully function at Level 2. Automation will help achieve the moving to a level 2. Wants real-time updates (as in Level 2) to all stakeholders to include Master Person Index development. Workflow processing and an enrollee-centric portal will improve the timeliness. **2007 MITA:** **To Be:** Need something practical for users to access and research audit trails.	1	1			**X**				
ME Perform Population and Member Outreach	**Description:** Notifying prospective applications and current members about new benefits and population health initiatives; new program initiatives; education (EPSDT/FAMIS).									

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010 MITA: **To Be:** The agencies desire to move towards achieving Level Three as MITA standards become available. The agencies will work towards achieving consistency within the agency. DMAS wants to expand access to recipients (AVRS/Web) to achieve Level Two. **2007 MITA:** **To Be:** DMAS wants to expand access to recipients (AVRS/Web) to achieve Level Two. .	1	2			**X**				

ATTACHMENT C

CM Establish Case

Establish Case		
Item	**Details**	**VA "As-Is" Details**
Description	The Care Management, ***Establish Case*** business process uses criteria and rules to identify target members for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication. A case may be established for one individual, a family or a target population such as: ■ Medicaid Waiver program case management – Home and Community-Based Services – Other ■ Disease management ■ Catastrophic cases ■ Early Periodic Screening, Diagnosis, and Treatment (EPSDT) ■ Population management Each type of case is driven by state-specific criteria and rules, different relationships, and different data.	**2010 MITA:** All agencies establish cases for enrollment/assignment into PCCM, CMM, Baby Care/MICC FAMIS, FAMIS MOMS and Family Planning waiver. Other condition-based assignments occur via screening teams (institutional and community), referrals, internal claims data and assessments such as for foster care, alternative long term care MICC/Baby Care, substance abuse, early intervention and school based services. **2007 MITA:** DMAS also establishes cases for enrollment/assignment into PCCM, CMM, Baby care, FAMIS, FAMIS MOMS and, Family Planning Waiver. Other condition-based assignments occur via screening teams (institutional and community), referrals, internal claims data and assessments such as for foster care, alternative long term care, MICC and school based services.
Trigger Event	• Scheduled time to scan for new cases • Request to look into a specific member case • An alert triggered by other events, such as a targeted diagnosis or referral generated from information submitted on a claim	2. DMAS builds an appeal case on a recipient-by-recipient basis. DMAS sometimes also uses an established or resolved appeal case for further investigation, e.g., fraud, abuse or administrative recovery action.
Result	1. List of members associated with cases and programs 2. Needs assessment 3. Treatment Plan 4. Associated Providers List 5. Case file data 6. Communications data for providers, clients	6. DMAS includes outreach and follow-up.
Business Process Steps	Start: Apply criteria to data base of candidate cases 1. Identify candidates for new cases — Apply criteria for the care management program, e.g., patient characteristics, medical conditions, location, age 2. Identify data requirements — Both selection parameters and reporting	1. DMAS recognizes an enrollees request for an available benefit or service as a means of identifying a new case. 4. DMAS performs an additional step to routinely re-assess a case status and or receives re-assessment outcomes from other shared data sources.

CM Establish Case

Establish Case		
Item	**Details**	**VA "As-Is" Details**
	parameters to include such items as time period[s], data elements, data relationships 3. Identify new cases — Apply rules to data and identify new cases; create case folder for each 4. Assess needs — Apply needs template to individual case and record results 5. Select program — Based on needs, determined which program(s) are appropriate for the client 6. Establish treatment plan — Based on needs, establish treatment (care) plan which identifies the services the client needs to receive, the types of providers, the care setting, frequency, and expected results 7. Identify and confirm providers — Based on the treatment plan, select providers to deliver the services, contact and confirm availability, record decisions End – Establish case (or reject case)	
Shared Data	Member Information Provider Information Payment History Information Benefits/Reference Information Program Information	
Predecessor	**Manage Member Communication** **Manage Provider Communication** **Program Integrity Manage Case** **Manage Provider Grievance and Appeal** **Manage Member Grievance and Appeal** **Develop and Maintain Program Policy**	2. DMAS considers an enrollee request based on program information as a predecessor to establishing a case. 3. DMAS considers re-assessment as a predecessor.
Successor	**Manage Case** Send Outbound Transaction technical process **Manage Member Information** **Perform Population and Member Outreach** **Manage Member Communication** **Authorize Treatment Plan**	
Constraints	States and programs within states use different criteria to establish cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. EPSDT case management is not required, but states may choose to have it to strengthen	DMAS has multiple service delivery methods for the same or similar benefits such as, case management which is available through fee-for-service, managed care, waiver or a combination of arrangements. When the services starts; prior authorization requirements and

CM Establish Case

Establish Case		
Item	**Details**	**VA "As-Is" Details**
	preventive measures.	duration of the service can vary across delivery systems.
Failures	Details of the case are inconsistent with criteria; the case is discontinued.	DMAS considers a lack of case establishment to be a failure as it eliminates the possibility to realize cost savings through preventative care and coordinated services.
Performance Measures	• Time required to establish a case • Effectiveness of selection criteria in determining real cases	

Establish Case [Care Management]: Business Capabilities

Establish Case				
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 consists primarily of manual compilation of data.	Mixes of manual and automated processes are used.	The process is fully automated to the extent possible. The Trigger establishing the case contains MITA standard interface data to populate the case record. Additional information is obtained via automated messaging. The process is fully automated with use of MITA definitions, standard definitions and Service-Oriented-Architecture concepts.	
VA As Is	**2010 MITA:** Most if not all agencies use a mixture of manual and automated processes. **2007 MITA:** DMAS uses a mix of manual and automated processes particularly during the initial screening of a potential waiver case.			
VA To Be		**2010 MITA:** The state agencies would like for the automated rules to apply to case management. The		

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		agencies would like to move more towards using a one system methodology. **2007 MITA:** DMAS would like for the automated rules to apply to case management.		
Does this business process use standards?	Medicaid enterprise uses State specific data standards.	Case data may be a mixture of HIPAA data standards and State specific standards.	Case data meet MITA standard interface requirements.	
VA As Is	**2010 MITA:** The business rules are used as the standard in this process.			
VA To Be		**2010 MITA:** The agencies would like to move towards using HIPAA data standards as well as state and program specific standards.		
How does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	The business process consists primarily of manual processes (e.g. telephone contacts, facsimile, letters) to gather and share information between social service agencies, physician offices and other provider types to establish cases.	Medicaid enterprise collaborates with other agencies. Authorized users are permitted to access other databases and retrieve pertinent information about the member (i.e. eligibility, claims history) improving over Level 1.	MITA data standard interfaces are used to exchange information between agencies and entities improving over Level 2.	
VA As Is	**2010 MITA:** Many agencies are at a level 1 with using			

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	manual processes to gather and share information in establishing cases.			
VA To Be		**2010 MITA:** Some agencies are meeting thresholds of collaborating with other agencies at a level 2. The state agencies would like to move towards meeting all thresholds at this level.		
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	Manual processes may adversely impact timeliness.	Introduction of automation increases timeliness over Level 1.	The use of MITA data definitions and standard interfaces improves the timelines over Level 2. The process can be completed, on the average, within 7 business days.	
VA As Is	**2010 MITA:** Business processes are monitored to ensure timeframes are being met. **2007 MITA:** Business processes with thresholds or mandated requirements for timeliness (such as managed care assignment within 45 to 60 days) are monitored to ensure timeframes are being met.			

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
VA To Be		**2010 MITA:** Agencies are meeting some thresholds in level 2 and would like to continue to move towards meeting this level. **2007 MITA:** DMAS would like to move towards a more direct link to case-making data, e.g., eligibility and disability; also having access to performance data such as the number of applications received and processed monthly.		
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual processes can adversely impact accuracy.	Automation improves accuracy and consistency of data used in this process over Level 1.	Use of MITA standardized interfaces and data definitions ensures accuracy of information. Data accuracy is measured at 90% of total data collected.	
VA As Is	**2010 MITA:** The **Establish Case** Business process is mostly manual during eligibility determination and initial screening input is non-standard across the business process.			

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	2007 MITA: The **Establish Case** Business process is mostly manual during eligibility determination and initial screening input is non-standard across the business process.			
VA To Be		**2010 MITA:** The agencies would like to automate the application process. Not all member types (Aged/Blind/Disabled) are automated. This automation would improve interoperability between agencies. **2007 MITA:** DMAS would like for automation and standardization of business process to improve and encourage interoperability between agencies.		
How accessible is the information used in this process?	The access to non-standardized and/or state specific data is controlled manually and may take several business days.	A mix of manual and automated processes with the use of HIPAA standards provides immediate on-line data access for some information to authorized users improves over Level 1.	Use of standardized MITA data definitions and interfaces allows immediate access to data with few exceptions. The process has immediate access to standardized real-time data. Data access takes no more than 3 seconds.	

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
VA As Is	**2010 MITA:** Most agencies are at a level 1. There are no HIPAA data standards being used at this level and most activities are manual.			
VA To Be		**2010 MITA:** The agencies would like to automate processes with the use of HIPAA standards (HL7) for immediate data access.		
Business Capability Quality: Cost Effectiveness				
What is the ratio of the cost to perform this process compared to the benefits of the results?	It is difficult to determine the cost-effectiveness.	The process meets Medicaid enterprise budget guidelines with focus on cost containment and improvement of effectiveness.	The process demonstrates the value projected by the Medicaid enterprise with staff focused on ensuring quality of case information and driving positive health outcomes.	
VA As Is	**2010 MITA:** The process requires a sizeable staff because of limitations in accessing eligibility determination and maintenance information for members. **2007 MITA:** The process requires a sizeable staff			

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	because of limitations in accessing eligibility determination and maintenance information for members.			
VA To Be		**2010 MITA:** The agencies would seek automation to help minimize the impact of a large staff dedicated to manual processes like screening and continued eligibility re-certification and verification. **2007 MITA:** DMAS would seek automation to help minimize the impact of a large staff dedicated to manual processes like screening and continued eligibility re-certification and verification.		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process relies primarily on manual and may be negatively impacted.	Combination of manual and automated processes results in increased efficiency over Level 1.	The process is automated to the extent possible. Optimal efficiency is achieved.	
VA As Is	**2010 MITA:** The initial steps of this process are labor-intensive and “stove-piped” for all agencies.			

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	2007 MITA: For DMAS, the initial steps of this process are labor-intensive and "stove-piped."			
VA To Be		**2010 MITA:** The agencies would like an automated process so that cases are established more easily and efficiently. (Example: A birth certificate would trigger an enrollment) **2007 MITA:** DMAS would like an automated member profile so that cases are established more easily and efficiently.		
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The manual process may adversely impact accuracy.	Increased automation improves accuracy over Level 1.	The use of MITA standard interfaces and data definitions further improves accuracy over Level 2. The process produces measurable results most of the time and consistently applies business rules. Accuracy of results is at least 95%.	
VA As Is	**2010 MITA:** The **Establish**			

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	Case Business process has steps that are labor-intensive and attempts to meet requirements for timeliness and accuracy. Not all enrollment requirements are met all of the time. **2007 MITA:** The **Establish Case** Business process has steps that are labor-intensive but manages to meet requirements for timeliness and accuracy.			
VA To Be		**2010 MITA:** All agencies seek automation to help improve timeliness and accuracy for establishing and maintaining cases. **2007 MITA:** DMAS would seek automation to help improve timeliness and accuracy for establishing cases.		
Business Capability Quality: Utility or Value to Stakeholders				

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
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.	
VA As Is	**2010 MITA:** Business process complies with agency and state requirements. **2007 MITA:** Business process complies with agency and state requirements.			

Establish Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
VA To Be		**2010 MITA:** The agencies seek automation that is easy to modify and implement based on changing needs, polices and goals. **2007 MITA:** DMAS would seek automation that is easy to modify and implement based on changing needs, polices and goals.		

CM Manage Case

Manage Case		
Item	**Details**	**VA "As-Is" Details**
Description	The Care Management ***Manage Case*** business process uses State-specific criteria and rules to ensure appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as: ■ Medicaid Waiver program case management ■ Home and Community-Based Services ■ Other agency programs ■ Disease management ■ Catastrophic cases ■ Early Periodic Screening, Diagnosis, and Treatment (EPSDT) These are individuals whose cases and treatment plans have been established in the Establish Case business process. It includes activities to confirm delivery of services and compliance with the plan. Also includes activities such as: ■ Service planning and coordination ■ Brokering of services (finding providers, establishing limits or maximums, etc.) ■ Facilitating/Advocating for the member ■ Monitoring and reassessment of services for need and cost effectiveness. This includes assessing the member's placement and the services being received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs.	**2010 MITA:** Money Follows the Person (MFP) should be included into the program listing since this program does include Case Management. **2007 MITA:** As part of the description DMAS notes that it also provides direct oversight for Development Disabilities waiver and Tech waiver members. For Medicaid Waiver Program, DMAS notes that some waivers do not have case management. As a case that may also be established and managed DMAS includes among others: Maternal Infant Child Coordination, Family Planning Waiver, Managed Care, Client Medical Management and, Fraud and abuse.
Trigger Event	1. Scheduled time to review case 2. Receipt of information regarding services delivered/not delivered(including claims information) 3. Receipt of benefit/policy changes that may affect a treatment plan 4. Receipt of information regarding an enrollment change, including disenrollment 5. Receipt of information regarding change in member's conditions or situation	**2010 MITA:** Another trigger event that should be added to the list is 'Returned Mail'. Returned mail will have an effect on enrollment of members because this disrupts benefits. **2007 MITA:** 1. DMAS also includes annual renewals of eligibility as a scheduled trigger event. 2. DMAS also includes among other specific

CM Manage Case

Manage Case		
Item	**Details**	**VA "As-Is" Details**
		requests: appeals and grievances, fraud and abuse.
Result	■ Case history is updated with revision to the following: o Changes to the case history o Needs assessment changes o Treatment Plan changes o Associated Providers List o Case file data (e.g., contact dates and times) o Content of communications to be sent to providers, members	DMAS notes that some needs assessment and treatment plan cases can be escalated to another level of review or to a higher or lower level of service. Additionally, results can include improved health and social outcomes.
Business Process Steps	Start: Review case (review of the member's status and needs) Based on review, take follow-up action, as needed, to: ■ ID services delivered, issues impeding delivery of service and/or member's progress: ■ Establish appointment with member to review case status ■ Contact provider(s) to review member's progress ■ Review services provided (claims payment information) ■ Close case for non-chronic conditions or change in member's status ■ Revise treatment plan to: o Add or remove services o Change nature of plan (e.g. shifting drug regimen, shifting from drug to behavioral) o Reassess needs ■ Revise expected results ■ Prepare communication data sets for the members and providers ■ Verify that updates to appropriate data store have been made or make updates End: Send communications data sets to: ■ **Manage Member Communications** ■ **Manage Provider Communications**	1. During intake for tech waiver, DMAS will participate in the assessment process.
Shared Data	Member Information Provider Information Payment History Information Benefits/Reference Case History	

CM Manage Case

Manage Case		
Item	**Details**	**VA "As-Is" Details**
	Assessment protocol Treatment Plan protocol Disease data store	
Predecessor	■ **Establish Case** ■ **Enroll Member; Disenroll Member** ■ **Manage Payment Information**	
Successor	■ **Manage Member Communication** ■ **Manage Provider Communication**	
Constraints	States and programs within states use different criteria to manage cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. EPSDT case management is not required, but states may choose to have it to strengthen preventive measures.	Service availability and delivery systems differ and can impact treatment.
Failures	Information required to Manage Case is not available, or is inaccurate	
Performance Measures	Cases are updated within the timeframe specified by State policy Movement towards desired health care outcomes as a result of case management as a performance measure for the future.	DMAS does not have a uniform standard for assessing and measuring performance of all the target member populations impacted by the **Manage Case** business process. For each target group a different aspect of the program may be assessed and measured; for example, DMAS may monitor timeliness of managed care assignments and timeliness of re-assessment screenings for waiver recipients.

CM Manage Case: Business Capabilities

CM Manage Case				
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 consists primarily of manual, paper based steps. Information is manually compiled; decisions based on interventions are subjectively determined.	This process is a mix of manual and automated reporting processes. Compiled data includes a mix of information gathered manually and automated reports.	Automation of most activities is in the workflow process. Notifications, requests for information, and other communications are transmitted using EDI standards.	
VA As Is	**2010 MITA:** Most agencies are operating at a Level 1 with most business processes primarily manual. Some agencies are in a Level 2. **2007 MITA:** DMAS has **Manage Case** business processes that are primarily manual.	**2010 MITA:** Some agencies are operating in a level 2. **2007 MITA:** Some DMAS **Manage Case** program areas scan documents; have automated case files that are shared among case managers. Some case files are web enabled like level 3.		
VA To Be			**2010 MITA:** All agencies would like to get to a Level 3 with the goal of having the same level of technical functionality. **2007 MITA:** Most DMAS **Manage Case** units want to get to level 3 with the primary goal of having all	

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
			units having the same level of technical functionality.	
Does this business process use standards?	Manual actions are used to monitor compliance thresholds established by state and federal regulations, professional standards, or administrative rules governing the appropriate management of a case. Case data is indeterminate.	A mix of manual and automated processes is used to monitor compliance thresholds established by state and federal regulations, professional standards, or administrative rules. Some case data is based on HIPAA data standards.	MITA standard interfaces are used.	
VA As Is	**2010 MITA:** DMAS and other agencies use a manual process to monitor compliance thresholds.			
VA To Be		**2010 MITA:** The goal of DMAS and the other agencies is to automate the processes to monitor compliance thresholds.		
How does the Medicaid agency collaborate with other agencies or entities in performing this process?	The business process consists primarily of manual processes (e.g., telephone contacts, facsimile, letters) to gather and share information between social services agencies, physician offices, and other provider types to coordinate care.	An automated process documents care plan and tracks cases. Authorized users are permitted to access other databases and retrieve pertinent information about the patient (i.e., eligibility, claims history).	Medicaid enterprise and other agencies collaborate through specific agreements to share responsibility in the identification, management, and funding of cases.	
VA As Is	**2010 MITA:** All agencies are			

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	working at a Level 1 with manually gathering and sharing information between agencies.			
VA To Be		**2010 MITA:** All agencies would like to continue to work towards automating process documents and moving towards a Level 2 and 3.		
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	The process meets State and Federal guidelines and national utilization review standards for timeliness of case reviews. Gathering of case data is dependent on manual processes and ability to locate information. Timeliness is negatively impacted due to the manual processes.	The process uses automated reports for tracking compliance with state and federal guidelines for case management and for the delivery of care, improving timeliness over Level 1.	All information needed to manage the case is immediately available. Any manual interventions that occur outside of the Level 3 business service is an exception.	
VA As Is	**2010 MITA:** All agencies are mostly manual for timeliness of case reviews. DMAS and the other agencies are able to meet or exceed program-specific requirements (mostly through automated support systems). **<u>Examples of Timeliness Processing:</u>** ▪ Program-specific	**2010 MITA:** No changes **2007 MITA:** Those programs at DMAS that have automation are able to meet stricter time requirements for example, the FAMIS program is able to meet a 10-day eligibility and enrollment requirement.		

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	requirements are unchanged. ▪ However, all program areas are bound to the Department of Social Services 45 day limit to determine overall Medicaid program eligibility. Some exceptions apply for time standards and they are: 10 days for Pregnant Woman and 90 days for Disability Determination. **2007 MITA:** DMAS **Manage Case** programs are mostly manual. Since there isn't a standard for how timeliness is measured across programs, DMAS is able to meet or exceed program-specific requirements (mostly through automated support systems) such as 14 days to determine appropriateness for a waiver, 3 days to enter Baby care information and 5 days to process level of care for long term care and waivers. However all program areas are bound to the Department of Social Services 45 day limit to determine overall Medicaid program eligibility.			

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
VA To Be		**2010 MITA:** Mostly meeting Level 2 requirements. The goal is to move into compliancy for Level 2 and move towards a Level 3. **2007 MITA:** DMAS wants all **Manage Case** business processes to be more automated in order to handle cases in a more timely manner; particularly entry of enrollment and eligibility information into VAMMIS.	**2010 MITA:** Virginia Health Information (VHI) is another state agency that data sharing should be set-up for. **2007 MITA:** DMAS **Manage Case** programs would like to have data sharing with other state agencies: DMV, DSS, Taxation, VDH and others.	
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Manual processes result in subjective selection of data to be used. Some data may be incomplete, inaccurate, or irrelevant.	Automation and use of HIPAA standards increases accuracy and consistency of data over Level 1.	Use of MITA standard interfaces and data definitions improves accuracy of data over Level 2. Data accuracy is measured at 90% of total data collected.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Almost all DMAS research processes for **Manage Case** has manual components. DMAS applies			

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	different case standards based on program area for data.			
VA To Be		**2010 MITA:** All agencies would like more automation for their processes. More web access for the provider community is desired. The providers would like to enter data one time. **2007 MITA:** DMAS **Manage Case** programs want more automation for their processes. They want more web access for themselves and providers.		
How accessible is the information used in this process?	The process manually gathers State-specific data elements. Access to data is controlled manually. Data access may take several business days.	The process is automated making information immediately available to authorized users. Data content and format uses its version of national data standards (e.g., HIPAA) for interfaces. It may use State specific standards for processing. The process uses on-line access to data. Data access is faster than at Level 1.	The process utilizes MITA standards for its interfaces and processing. The process has immediate access to standardized data. Data access takes no more than 3 seconds.	
VA As Is	**2010 MITA:** All agencies are			

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	manually gathering state specific data elements with the desire to move to a Level 2.			
VA To Be		**2010 MITA:** All agencies want more automation for their processes. More web access for themselves and the providers is desired.		
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 or established dollar thresholds for cost savings.	Improvements in automation increase cost effectiveness over Level 1.	The process demonstrates the Return on Investment projected by the Medicaid enterprise due to MITA standard interfaces. Cost effectiveness improves over Level 2.	
VA As Is	**2010 MITA:** No changes for all agencies. **2007 MITA:** DMAS would like to have enrollees assigned to their targeted programs sooner. While an enrollee goes through the 45-day process of enrollment with the Department of Social Services, the enrollee may not be receiving targeted services or the services that they are receiving are through a delivery system with a	**2010 MITA:** No changes for all agencies. **2007 MITA:** For programs like FAMIS that are more automated are able to re-direct staff to other work including marketing and outreach.		

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	higher reimbursement.			
VA To Be			**2010 MITA:** All agencies are striving to collaborate with other agencies and move into a Level 3. The Department of Education needs to be added as an agency to collaborate with. **2007 MITA:** Collaboration with other state agencies is a highly desired goal for the **Manage Case** programs.	
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	Manual processes identify services or actions to be performed and points for intervention. Opportunities for improvements exist at many points in the process.	Combination of manual and automated processes results in reduced time to identify services/actions to be performed and points for intervention. Efficiency improves over Level 1.	The process is fully automated to push and pull data from other systems and improve communications between case manager, member, and providers.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Research is usually done on a case-by-case basis with few opportunities to group like or similar requests together.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** DMAS has automated applications for verifying eligibility but similar functionality is not available to inquiry at the **Manage Case** level.		
VA To Be		**2010 MITA:** No changes from 2007 MITA.	**2010 MITA:** No changes from 2007 MITA.	

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		2007 MITA: All **Manage Case** programs would like more automated processes and less paper processes.	**2007 MITA:** DMAS wants more automated sharing of data across state agencies.	
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	The process meets State and Federal expectations for member education, coordination of care between providers, and maintaining the plan of care. Decision making for the process is manually performed using established parameters and guidelines and may result in some subjective and inconsistent decisions.	Decision making for the process is based on Medicaid enterprise policy which has been automated resulting in uniform decisions in most situations. Outliers are reviewed on case-by-case basis using State and Federal guidelines. Process results are more consistent than at Level 1.	MITA standard interfaces and automation of the workflow further increase accuracy over Level 2. Process results are consistent at least 95% of the time.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** There is some manual documentation of cases throughout the **Manage Case** programs. There is disparity between fee-for-service and managed care delivery systems that may produce inconsistent results among enrollees.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Most **Manage Case** programs have automated result documents. These documents can be reviewed on VaMMIS.		
VA To Be		**2010 MITA:** No changes	**2010 MITA:** No changes	

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		from 2007 MITA. **2007 MITA:** DMAS would like an interface with the MCOs.	from 2007 MITA. **2007 MITA:** DMAS **Manage Case** programs would like standard automated interfaces within the agency and with other outside agencies.	
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders?	Stakeholder satisfaction is negatively impacted 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 level of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	Medicaid enterprise conducts internal and external audit/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		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** DMAS **Manage Case** programs benefit from the automation that they have.		
VA To Be			**2010 MITA:** No changes	

CM Manage Case				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
			from 2007 MITA. **2007 MITA:** DMAS would like to move to this level with standard intra agency interfaces and standard interfaces with other state agencies.	

CM Manage Medicaid Population Health

Manage Medicaid Population Health		
Item	**Details**	**VA "As-Is" Details**
Description	This business process designs and implements strategy to improve general population health by targeting individuals by cultural or diagnostic or other demographic indicators. The inputs to this process are census, vital statistics, immigration, and other data sources. This business process outputs materials for: ■ Campaigns to enroll new members in existing program ■ New program areas, services, etc. ■ Updated Benefits/Reference , Member , Provider Communications with Impacted Members, Providers, and Contractors (e.g., program strategies and materials, etc.)	Members are targeted as indicated. Outputs are program specific.
Trigger Event	■ Receipt of data from census, vital statistics, public health departments, immigration, and other data sources ■ Scheduled requests for data from above sources ■ Receipt of data from other Business Areas ■ Receipt of new population or problem-specific legislated health improvement initiatives ■ Other originators (e.g., federal actions, constituency interests, etc.)	DMAS includes state mandates and recommendations by the DMAS Board as trigger events. DMAS adds new program availability as a trigger event.
Result	■ The outputs are data to support educational materials, communications, and other media.	DMAS also considers improved health and social outcomes as a result.
Business Process Steps	1. Start: Receive data/data request 2. Analyze data 3. Develop strategies 4. Develop communication data set 5. Determine changes to benefits 6. Distribute communication materials data set via Send Outbound Transaction to a. Manage Member Communications b. Manage Provider Communications c. Manage Contractor Communications	**2010 MITA:** 2. To further clarify 'Analyze Data' this step is to further common state goals by analyzing data with state partners and to prevent certain outcomes (for example, low birth weight babies). **2007 MITA:** DMAS notes that this becomes an iterative process as enrollees lose and regain eligibility. 7. DMAS tracks thru paid claims. 8. Recipients can be in programs more than once.

CM Manage Medicaid Population Health

Manage Medicaid Population Health		
Item	**Details**	**VA "As-Is" Details**
	7. End: Prepare data set to support communications or updates to reference information (e.g., benefit plan)	
Shared Data	Member Information Provider Information Contractor Information Benefits/Reference Information Data from external agencies including: census, vital statistics, immigration, and various health registries	**2010 MITA:** Data from external agencies has provided quality improvements by being able to look at the core system of care.
Predecessor	There are several Business Processes that can result in the interest or need to reach out to the Medicaid population in an attempt to improve behavior, promote prevention, etc.: Program Integrity **Manage Case** **Monitor Performance and Business Activity** **Develop Agency Goals and Objectives** **Manage Member Grievance and Appeal** **Manage Provider Grievance and Appeal** **Develop and Maintain Program Policy**	
Successor	**Manage Applicant and Member Communications** **Perform Population and Member Outreach** **Manage Provider Communications** **Perform Provider Outreach** **Manage Contractor Communications** **Perform Potential Contractor Outreach** **Develop and Maintain Benefit Package** **Maintain Benefits/Reference Information** **Manage Member Information** **Manage Provider Information**	
Constraints	Potential lack of inter-agency coordination mechanisms including the ability to share data across agency lines. Potential political and inter-agency	DMAS lists HIPAA as a constraint as well as our inability to interface with other agencies.

CM Manage Medicaid Population Health

Manage Medicaid Population Health		
Item	**Details**	**VA "As-Is" Details**
	conflicts over appropriate use of health care information.	
Failures	Ability to gather data to support strategies is impaired by interagency communication, lack of access to information	Other failures include a lack of opportunity for preventative measures which can make care and management more costly.
Performance Measures	% of target population receiving materials % change in frequency of desired outcome in target population	DMAS does not have a uniform standard for assessing and measuring performance of all the target member populations impacted by the **Manage Medicaid Population Health** business process. For each target group a different aspect of the program may be assessed and measured; for example, DMAS may monitor timeliness of managed care assignments and timeliness of re-assessment screenings for waiver recipients.

Manage Medicaid Population Health: Business Capabilities

Manage Medicaid Population Health				
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 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	**2010 MITA:** No changes from the 2007 MITA. **2007 MITA:** Most of the programs at DMAS are siloed and they use different trigger events, some of which are automated. Management is primarily manual and conducted by paper or phone. Population Health Management materials are manually prepared and updated.	**2010 MITA:** 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. **2007 MITA:** 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		

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		and health needs based on increased standardization of administrative data, and improved data manipulation for decision support. In addition to phone and paper, states use Websites, Agencies use TV, radio and advertisements to distribute outreach information to targeted members.		
VA To Be			**2010 MITA:** All agencies desire to move towards a Level 3. **2007 MITA:** 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.	
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	**2010 MITA:** All agencies continue to pursue national standards for data standards.			

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	This will make all state systems consistent and foster interoperability between systems.			
VA To Be		**2010 MITA:** 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	**2010 MITA:** 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		**2010 MITA:** Some agencies are using state systems or proprietary		

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		systems to track cases. Continue to move towards a Level 2.		
Business Capability Quality: Timeliness of Process				
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	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** 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.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** 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.		
VA To Be		**2010 MITA:** Continue to move towards total compliance in Level 2.		
Business Capability Quality: Data Access and Accuracy				
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	

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		increased automation improving accuracy over Level 1.	accuracy to 90% or better.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** 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.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** While automation helps to improve accuracy, it is not a guarantee of access to needed information for all enrollees.		
VA To Be		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** DMAS would like to improve access to program information for the fee-for-service population.		
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	**2010 MITA:** All agencies are operating at a Level 1.			

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	Access to data is a manual process.			
VA To Be		**2010 MITA:** 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 f 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	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Managing the Medicaid Population Health for the fee for service population is very labor intensive and requires a large staff.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Targeting enrollees for managed care and FAMIS is automated; most staff focuses on monitoring, auditing and new program development.		
VA To Be	**2010 MITA:** No changes from 2007 MITA.	**2010 MITA:** No changes from 2007 MITA.		

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	2007 MITA: DMAS desires more automation for targeting populations served by fee for service.	**2007 MITA:** 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.		
Business Capability Quality: Effort to Perform; Efficiency				
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	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** 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.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** 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		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** DMAS would		

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		like more timely identification of targeted populations to ensure faster and better service delivery.		
Business Capability Quality: Accuracy; Usefulness of Process Results				
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	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** 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.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** The FAMIS program provides limited web resources to its members who can access it.		
VA To Be		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** DMAS would like to engage in data sharing and interfacing with contracted vendors and sister agencies for distributing needed		

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		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	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** DMAS is meeting its requirements in this area.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Automation of assessment tools and program eligibility has been introduced to long term care and FAMIS programs respectively.		
VA To Be		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** DMAS would like more fee for service processes to be automated		

Manage Medicaid Population Health				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		for better population health management.		

CM Manage Registry

Manage Registry		
Item	**Details**	**VA "As-Is" Details**
Description	A medical "registry" for the purposes of MITA is tool that is used to consolidate related records from multiple sources into one comprehensive data store. This data store may or may not be resident within the Medicaid information system. The **Manage Registry** business process receives requests for information and prepares updates for a specific registry (e.g., immunizations, cancer, etc.) and responds to inquiries with response data set.	**2010 MITA:** The Cancer and Immunization registry at VDH does not fit for claims and eligibility data. **2007 MITA:** VA's registries are in the form of stand alone repositories of claims, encounter and eligibility data.
Trigger Event	Receipt of inquiry data set Receipt of data to update registry	**2010 MITA:** The Cancer, HIV/AIDS or Vital Statistics registries do not delete records from their registry/databases. **2007 MITA:** VA does not delete records from its registry/database.
Result	Response to inquiry data set is prepared and sent Update data set is prepared Response to update request is sent	Informal registries are also created by complex SAS queries against established registries of data as previously mentioned in the "As-Is" description.
Business Process Steps	Start: Receive update request 1. Receive data 2. Validate data 3. Apply applicable updates to the registry 4. Prepare reply data set End: Log reply sent	**2010 MITA:** 2. Validate Data should also have a step representing what occurs when 'Invalid Data' is found on the database. The 'Invalid Data' business step should initiate a manual process to correct the core system of record. **2007 MITA:** 1. VA includes the receipt of claims, encounter and eligibility data in this initial step.
Shared Data	Registry (e.g., immunizations, cancer, etc.) Data sources needed for validation of requestor	
Predecessor	**Business Relationship Management Receive Inbound Transaction** – inquiry or contributing data **Manage Provider Communications**– inquiry or contributing data **Develop Agency Goals and Objectives** – requests for information	
Successor	**Manage Provider Communications** **Manage Contractor Communications** **Develop Agency Goals and Objectives**	
Constraints	State and Federal regulations regarding entities authorized to access registry information	Missing data elements.
Failures	Requester is not authorized to access Registry	

	Data updates cannot be applied because record cannot be found	
Performance Measures	Examples of Measures: 1. Time to complete registry update = __days 2. Successful delivery rate of responses = __%	VA does not have any formal performance measures for this process.

Manage Registry: Business Capabilities

Manage Registry				
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?	This process consists primarily of manual, paper based steps. Information is keyed in manually in standard format and content.	This process uses a mix of manual and automated processes for data collection. Compiled data includes both information gathered manually and data entered into the registry and data files uploaded to the registry in standard data formats.	The process automates most activities in the workflow for data collection. Data is entered into standard Web forms and transmitted to the registry as data files or introduced from proprietary data sources using MITA standard interfaces.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** VA's repository of data is non standard and disjointed; data elements are duplicated. Data access is limited to specific classifications of employees.			
VA To Be		**2010 MITA:** Moving towards a Level 2 where there is a mix of automation and manual processes for data collection. Many steps in process. **2007 MITA:** VA can see the benefits of having a well appointed registry and		

Manage Registry				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		would like to begin with a data warehouse.		
Does this business process use standards?	The process uses minimal standards for collection of data into the registry and local data standards.	The process uses State and Federal standards for collection of data into the registry.	The process uses the MITA standard interfaces and data definitions for collection of data into the registry, updates, and changes.	
VA As Is	**2010 MITA:** Most agencies use minimal standards for collection of data into the registry.		**2010 MITA:** The Health Department uses the CDC standard interfaces and data definitions for collection of data into the registry, updates and changes.	
VA To Be		**2010 MITA:** Move towards standardizing processes for collection of data into the registry.		
Does the Medicaid enterprise collaborate with other agencies or entities in performing this process?	The Medicaid enterprise may collaborate with other entities but collaboration uses manual processes (e.g., telephone contacts, facsimile, letters) to gather and share information between social services agencies, physician offices, hospitals and other providers.	The process uses a mix of manual and automated processes to collect information from the Medicaid enterprise and social services agencies, physician offices, hospitals, and other providers. Parties agree on format and content, security and privacy, and how to access shared information.	The Medicaid enterprise, other agencies, and providers agree to use MITA standard interfaces and Service Level Agreements (SLA) for updates to registries and access to shared information.	
VA As Is	**2010 MITA:** Some agencies operating at a Level 1 using	**2010 MITA:** Many agencies operating at a		

Manage Registry				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	manual processes to gather and share information between agencies.	Level 2 with a mix of manual and automated processes to collect information.		
VA To Be		**2010 MITA:** The goal of all agencies is to have interoperable systems and processes.		
Business Capability Quality: Timeliness of Process				
How timely is this end-to-end process?	This process meets State and Federal guidelines for data collection timeliness for reporting to the Registry. The process can be completed, in many business days.	The process can be completed, in less time than at Level 1.	MITA standard interfaces and SLAs further reduce the time to complete the process than at Level 2.	
VA As Is	**2010 MITA:** Many agencies **Manage Registry** programs are manual. Since there isn't a standard for how timeliness is measured across programs, many agencies are able to meet or exceed program-specific requirements (mostly through automated support systems). **2007 MITA:** Claims, encounter and eligibility data is available immediately to users via MMIS. Accessing larger sets must be done manually.			
VA To Be		**2010 MITA:** All agencies want **Manage Registry**		

Manage Registry				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		business processes to be more automated in order to handle more cases in a timelier manner. **2007 MITA:** 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.		
Business Capability Quality: Data Access and Accuracy				
How accurate is the information used in this process?	Data may be incomplete, inaccurate, irrelevant and untimely. Often additional information must be requested.	Accuracy and consistency of data improves over Level 1 due to increased use of automation and data standards.	Use of MITA standard interfaces and data definitions ensures accuracy of data. Data accuracy is higher than at Level 2.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Accessing information is mostly a manual process. Updates are made to individual claims, encounter and enrollee eligibility records before they are stored to monthly extracts for users to access.	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** VaMMIS requires claims and encounter data to be in standard formats.		

Manage Registry				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	Data elements are duplicated.			
VA To Be		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Additional edits would improve data accuracy; data warehouse with an intuitive, user friendly front-end would improve access.		
How accessible is the information used in this process?	Access to data is controlled manually. Data access may take several business days.	The process uses on-line access to Registry data but compilation of the data is a mixture of manual and automated activities. Data access takes less time than Level 1.	The process has immediate access to standardized data. Data access takes less time than at Level 2.	
VA As Is	**2010 MITA:** Most agencies control data manually.			
VA To Be		**2010 MITA:** Move towards Level 2 compliance.		
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 effectiveness increases with automation and elimination of local standards.	The process demonstrates the improvement value projected by the Medicaid enterprise.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** VaMMIS processes the claims, encounter and eligibility data well. VA uses a prior authorization vendor to key			

Manage Registry				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
	data into the system.			
VA To Be		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** VA would like to increase automation, data sharing and interfacing.		
Business Capability Quality: Effort to Perform; Efficiency				
How efficient is this process?	The process relies primarily on manual activities.	Efficiency increases with automation allowing staff to focus more on analyzing Registry data and issuing alerts when problems are detected.	Reaches maximum efficiency where alert messages are automatically sent to staff who can focus on resolutions of problems and future improvements.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** Claims, encounter and eligibility registries are separate and do not "talk" to each other.			
VA To Be	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** More data sharing internally and externally would improve efficiency.			
Business Capability Quality: Accuracy; Usefulness of Process Results				
How accurate are the results of this process?	Decisions are manual and based on non-standard information, which may result in inconsistent decisions.	Decision making for the process is automated based on Medicaid enterprise policy resulting in	The process consistently applies business rules resulting in more uniform decisions than at Level 2.	

Manage Registry				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		more uniform decisions than at Level 1.		
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** VA has sufficient automation at this level.			
VA To Be		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** VA would like to validate encounters more frequently.		
Business Capability Quality: Utility or Value to Stakeholders				
How satisfied are the stakeholders (members, providers, tax payers)?	There are issues regarding timeliness, accuracy, completeness of the Registry data and negatively impacting stakeholder satisfaction.	Satisfaction improves over Level 1 due to automation.	Satisfaction is higher than Level 2 due to improved access to timely and accurate data and automated reporting.	
VA As Is	**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** VA has sufficient automation at this level.			
VA To Be		**2010 MITA:** No changes from 2007 MITA. **2007 MITA:** VA would like to have automated maintenance of claims, encounter and eligibility		

Manage Registry				
Capability Question	**Level 1**	**Level 2**	**Level 3**	**Level 4 & 5**
		data. VA would also like for enrollees to have automated medical records that are portable.		

Care Management

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(CM) Care Management										
CM Establish Case	**Description:** Uses criteria and rules to identify target member populations for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication.									
	2007 To Be: DMAS would like for the automated rules to apply to case management. DMAS would like to move towards a more direct link to case-making data, e.g., eligibility and disability; also having access to performance data such as the number of applications received and processed monthly. DMAS would like an automated member profile so that cases are established more easily and efficiently	1	2							**X**
	2010 To Be: DMAS and other participating agencies continue to express a desire for more automation of rules and processes and use of national standards; HIPAA and HL7.	1	2							
CM Manage Case	**Description:** CMS has provided no description of this business process other than that implied by its name.									
	2007 To Be: DMAS wants all Manage Case business processes to be more automated in order to handle cases in a more timely manner; particularly entry of enrollment and eligibility information into VAMMIS. Including more web access for themselves and providers	1	2							**X**

Care Management

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010 To Be: Users are interested in achieving interoperability with other agencies and increased web access for stakeholders. All agencies are looking towards higher levels of maturity and equal levels of techinical functionality.	1	2							
CM Manage Medicaid Population Health	**Description:** Designs and implements strategies to improve general population health through targeting individuals by cultural or diagnostic or other demographic indicators. The inputs to this process are census, vital statistics, immigration, and other data sources. The outputs are educational materials, communications, and other media.									
	2007 To Be: 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.	1	2							**X**
	2010 To Be: Participating agencies are still functioning at a Level 1 with desires to mature to a Level 2 with more automation.	1	2							
CM Manage Registry	**Description:** Operates a registry (such as for immunizations, cancer), receives continuous updates, responds to inquiries, and provides access to authorized parties.									
	2007 To Be: VA can see the benefits of having a well appointed registry and would like to begin with a data warehouse.	1	2							**X**

Care Management

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010 To Be: An ESS (Executive Support System) is under development. The agencies have made progress towards interoperability with increased utilization of standards and inter-agency collaboration for birth, death and laboratory reporting; immunization registry.	1	2							

ATTACHMENT D

Accountability Management

Accountability Management (AM)

AM: Conduct Routine Fiscal and Clinical Monitoring Process				
Item	**Details**			
Description	The ***Conduct Routine Fiscal and Clinical Monitoring*** business process monitors services, outcomes, and expenditures required to meet state and Federal reporting requirements. The process regularly examines the most current client, service, and provider/contractor data on service delivery and costs, service coverage and improvement, client outcomes, expenditures and other factors as required.			
MITA Reference	Source Process Name: *Conduct Routine Fiscal and Clinical Monitoring* Source Process Business Area: *Accountability Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client Information Outcomes and performance measures Budget and expenditure history		Services information Provider/contractor history Conceivably, all enterprise data	
AM: Conduct Routine Fiscal and Clinical Monitoring: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is done with a mix of tape, CD and some proprietary internal systems, using nonstandard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and multiple reviews may be conducted by different programs. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. The process is informed by a set of agency standardized data on clients, services and outcomes. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external data and stakeholders. Coordination cross agency improves coordination of monitoring activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Client, service, and provider/contractor information is accessible to any authorized party through HIEs statewide for monitoring purposes. This Level adds clinical data.	Client, service, and provider/contractor information is accessible to any authorized party through HIEs nationwide for monitoring purposes. This Level adds nationwide technical interoperability.
VA As Is: Virginia is mostly a 1 with some 2.				
VA To Be: Virginia hopes to continue moving toward a full 2.				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes	Internal agency	External agency	Non-state entity

	mostly automated	processes/interfaces mostly automated	processes/interfaces mostly automated	processes/interfaces mostly automated
VA As Is	Virginia ranges from a 1-3. CSBs with EHRs are at a level 3.			
VA To Be	Virginia will continue to work toward the next level.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: Virginia is a level 1 with some aspects of 2.				
VA To Be: Virginia will continue working toward becoming a full level 2.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: Virginia is a level 1 with some aspects of 2.	Some facilities are between a level 2 & 3.	CSBs with EHRs are at a level 3.		
VA To Be: Virginia will continue working toward becoming a full level 2.				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	Facilities range between levels 1-4.	DMAS and DBHDS are between a level 3 & 4.	CSBs are at level 4 with CCS.	
VA To Be:	Virginia will continue to work toward the next level.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems

	systems			
VA As Is:	Facilities range between levels 1-3.	Central Office is at level 3. DMAS is between a level 3 & 4.	CSBs are at level 4 with CCS.	
VA To Be:	Virginia will continue to work toward the next level.			

Accountability Management (AM)

AM: Develop and Manage Performance Measures and Reporting Process				
Item	**Details**			
Description	The ***Develop and Manage Performance Measures and Reporting*** business process establishes mechanisms and requirements for developing, managing, and reporting performance measures and other data for providers/contractors, quality, and outcomes, and to comply with state and federal reporting requirements. This process analyzes client and service histories and trends, costs, expenditures, and trends, assesses external factors affecting the program, assesses agency initiatives and plans, identifies significant measurable activities and outcomes, and creates and/or revises performance measures.			
MITA Reference	Source Process Name: *Develop and Manage Performance Measures Reporting* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	All Enterprise data State and federal measures		Shared analytical data State and federal requirements	
AM: Develop and Manage Performance Measures and Reporting: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Performance measures are determined in an ad hoc manner on an irregular basis. Performance measures are developed by meeting state and federal requirements, selecting measurable attributes, and obtaining staff and stakeholder input. Performance measures are limited by the available data; data available is the minimum necessary to meet reporting requirements. Data is reported as required. This Level complies with agency requirements.	Performance measures are determined on a regularly scheduled basis using a systematic and well defined process. The process uses the Web, video teleconferencing and other technologies to facilitate communications and process speed. The process is informed by a set of agency standardized data on clients and services. Data available increases; simple data is reported electronically. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external stakeholders. Communications are standardized across agencies and coordination cross agency results in improved efficiencies for joint measurement and reporting. Performance measures and reporting requirements are synchronized across agencies. cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Standardized client specific clinical data is accessible for performance and other measures via state HIEs, and data for those measures is automatically communicated. All health care agencies collaborate in creating common performance measures and reporting requirements between agencies and among all agency partners statewide. Potential performance measure choices are greatly expanded as the data available increases. This Level adds clinical data.	Performance and other measures algorithms are integrated into HIEs on a national scale. Data pertinent to the planning process is analyzed and transmitted in real time. Nationwide collaborations streamline measures with agency stakeholders nationwide. This Level adds nationwide technical interoperability
VA As Is: Facilities are at a level 1 with some aspects of level 2.	CSBs are at a level 2.			
VA To Be: Virginia will continue to work				

toward the next level.				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: Facilities are between levels 1 & 2.		CSBs are at Level 3.		
VA To Be: Virginia will continue to work towards the next level.				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is	CSBs are between levels 2 & 3. Facilities and Central Office are at level 2.			
VA To Be	Virginia will continue to work towards meeting level 3 criteria.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: Facilities range from levels 1-3.	CSBs and Central Office are between levels 2 & 3.			
VA To Be: Virginia will continue to work towards the next level.				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	Facilities range between levels 2 & 3 with some elements of level 4, i.e. CCS and sharing reports with	CSBs with EHRs are at Level 3.		

	the state.			
VA To Be	Virginia will continue to work towards the next level.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	Facilities are at level 2.	Central Office and some CSBs are at level 3.		
VA To Be	Virginia will continue to work towards the next level.			

Accountability Management (AM)

AM: Initiate Accreditation Process Process				
Item	**Details**			
Description	The ***Initiate Accreditation*** process provides assistance to providers/contractors in achieving and maintaining the accreditation and credentialing necessary for program participation.			
MITA Reference	None.			
Sample Data	Provider/contractor data		Accreditation and credentialing requirements	
AM: Initiate Accreditation Process: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is largely conducted manually and in an ad hoc manner. Materials are prepared and updated manually, and communications are by mail or in person. The process varies across multiple, siloed programs is uncoordinated, and nonstandard. Quality and consistency is variable. This Level complies with agency requirements.	Increased use of agency standards improves communication of information and technical assistance. Electronic materials and interfaces are available via a Web portal. Standard accreditation information is maintained and distributed to providers/ contractors via electronic media. This Level includes additional data and quality edits.	Accreditation assistance is available via state Web portals using BH-MITA and MITA standard data and interfaces and shared with other collaborating agencies. Accreditation and credentialing forms and processes are mostly conducted online, the process is tracked and completion documented. At this Level data is standardized against HL7 RIM.	Accreditation assistance is largely handled through HIEs statewide; alerts are automatic. All health care agencies collaborate in assisting providers/ contractors statewide with accreditation. Providers/ contractors can alert the agency electronically for assistance. This Level adds clinical data.	Accreditation assistance is largely handled through HIEs nationally; states can centralize assistance through HIEs as well. Nationwide collaborations streamline assistance to providers/ contractors anywhere in the country. This Level adds nationwide technical interoperability.
VA As Is:	DBHDS is mostly a level 2 with some aspects of level 3. Most facilities are at a level 2, some have aspects of level 1. (This area doesn't apply to CSBs because of licensing.)			
VA To Be:	Virginia will continue to move toward a level 3.			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	DBHDS is a level 2. Most facilities are at a level 2, some have			

	aspects of level 1.			
VA To Be	Virginia will continue to move toward a level 3.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is	Most facilities are at a level 2.			
VA To Be	Virginia will continue to move toward a level 3.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Central Office is a level 2. Most facilities are at a level 2, some have aspects of level 1.			
VA To Be	Virginia will continue to move toward a level 3.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	Most facilities are at a level 2.			
VA To Be	Virginia will continue to move toward a level 3.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	Most facilities are at a level 2.			
VA To Be	Virginia will continue to move toward a level 3.			

Accountability Management (AM)

AM: Initiate Case Process				
Item	**Details**			
Description	The ***Initiate Case*** business process uses criteria and rules to identify patterns or parameters of acceptable/unacceptable behavior, determine when action is needed, and open a case for further investigation. Each type of case is driven by different criteria and rules, different relationships, and different data.			
MITA Reference	Source Process Name: *Identify Candidate Case* Source Process Business Area: *Program Integrity Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Member Information Provider Information Payment History Information		Benefits/Reference Program Information Case Selection Parameters	
AM: Initiate Case: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily manual, using nonstandard formats and data. Requirements may be variable across agencies. The process is often lengthy and inconsistent in the application of the rules. This Level complies with agency requirements.	The process incorporates direct connectivity across agencies; Web interfaces; basic business rules; and enhanced consistency of process and timing. Formats and data are standardized within state health agencies, and information can be shared online. Increased availability of data electronically aids case identification. Case investigation is more automated, so consistency and set up time is improved. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Formats and data are standardized and automated within all state health agencies, and processes are shared and coordinated. Cases can be initiated from automated review of the data, and rules are consistently applied. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Formats, data and processes are standardized and automated using HIEs across all government agencies at all levels in the state. The process uses virtual administrative records and integrated systems to immediately set up cases for further investigation. Standards and cross agency communication reduce time needed to set the case in motion. This Level adds clinical data.	Formats, data and processes are standardized and automated using HIEs across all government agencies at all levels nationwide. The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual access to administrative and clinical data. This Level adds nationwide technical interoperability.
VA As Is: Virginia is mostly Level 1.	Some Level 2 is occurring.			
VA To Be:	Virginia will continue to move towards Level 2.			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: Virginia is mostly Level 1.	Some Level 2. The AVATAR program has some automation.	Some CSBs are at Level 3.		

VA To Be:		Virginia will continue to move toward the next level.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: Some Level 1 is occurring.	Virginia is mostly Level 2.			
VA To Be:	Virginia will continue to move towards the next level.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: Some Level 1	Virginia is mostly Level 2.	Some Level 3		
VA To Be:	Virginia will continue to move towards the next level			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is: Virginia ranges from Level 1-3	Virginia ranges from Level 1-3	Virginia ranges from Level 1-3		
VA To Be:	Virginia will continue to move toward the next level			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	Virginia is mostly Level 2	Some elements of Level 3.		
VA To Be:		Virginia will continue to move toward Level 3.		

Accountability Management (AM)

AM: Manage Case Process				
Item	**Details**			
Description	The ***Manage Case*** business process receives a case file from an investigative unit with the direction to respond to the case, participate in the case, or pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or client from the program; or the case may be terminated or suspended. 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.			
MITA Reference	Source Process Name: *Manage Case* Source Process Business Area: *Program Integrity Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Member Information Provider Information Payment History Information		Benefits/Reference Information Program Information Medical records requested from providers	
AM: Manage Case: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily manual, using nonstandard formats and data. Requirements may be variable across agencies. The process is often lengthy and inconsistent in the application of the rules. This Level complies with agency requirements.	The process incorporates direct connectivity across agencies; Web interfaces; basic business rules; and enhanced consistency of process and timing. Formats and data are standardized within state health agencies, and information can be shared online. Increased availability of data electronically aids the investigation process. Case investigation is more automated, so consistency and timeliness is improved. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Formats and data are standardized and automated within all state health agencies, and processes are shared and coordinated. Case investigation can be facilitated by automated review of the data, and rules are consistently applied. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Formats, data and processes are standardized and automated using HIEs across all government agencies at all levels in the state. The process uses virtual administrative records and integrated systems to further the investigation. Standards and cross agency communication reduce time needed to complete the investigation. This Level adds clinical data.	Formats, data and processes are standardized and automated using HIEs across all government agencies at all levels nationwide. The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual access to administrative and clinical data. This Level adds nationwide technical interoperability.
VA As Is: Virginia is mostly at Level 1	Some Level 2			
VA To Be:	Virginia will continue to move towards Level 2.			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**

All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: Virginia is mostly at a Level 1. Some	Some facilities have aspects of Level 2.	CSBs are operating at a Level 3.		
VA To Be:		Virginia will continue to work towards the next Level.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	Virginia is mostly Level 2.	Some Level 3. BHDS is a Level 3.		
VA To Be:	Virginia will continue to work towards the next Level.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: Virginia is mostly at a Level 1.	Some facilities are at Level 2.	Some aspects of Level 3 & 4 (e.g. shared licensing info).		
VA To Be:		Virginia will continue to work towards the next Level.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	Some aspects of Level 2.	Virginia is mainly at a Level 3 & 4.	Virginia is mainly at a Level 3 & 4.	
VA To Be:		Virginia will continue to work towards the next Level.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	Virginia is mostly at a Level 2.		CSBs exchange of data with the Central	

			Office is at a Level 4.	
VA To Be:		Virginia will continue to work towards the next Level.		

Accountability Management (AM)

AM: Manage Disallowances Process				
Item	**Details**			
Description	The ***Manage Disallowances*** process monitors and helps assure provider/contractor compliance with requirements for receiving funding and reimbursement. The process assists providers/contractors in adopting documentation and business practices that support obtaining sufficient and appropriate revenue, and protect them from vulnerability to revenue reductions. Different payers may have different criteria and rules.			
MITA Reference	None.			
Sample Data	Provider/contractor data Payment files		Provider/contractor contracts Payer requirements	
AM: Manage Disallowances Process: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is largely conducted manually and in an ad hoc manner. Materials are prepared and updated manually, and distributed by mail or in person. The process varies across multiple, siloed programs is uncoordinated, and nonstandard. Quality and consistency is variable. This Level complies with agency requirements.	Increased use of agency standards improves communication of information and technical assistance. Electronic materials and training are available via a Web portal. Standard educational information is maintained and distributed to providers/ contractors via electronic media. This Level includes additional data and quality edits.	Technical assistance materials are available via state Web portals using BH-MITA and MITA standard data and interfaces and are shared with other collaborating agencies. Repositories of requirements facilitate customized material development. Training courses are available online, and completion is documented. At this Level data is standardized against HL7 RIM.	Technical assistance is largely handled through HIEs statewide; regular training and messaging are automatic. All health care agencies collaborate in technical assistance to providers/ contractors statewide. Clinical and administrative information can automatically trigger technical assistance material to be sent or alert the agency for assistance. This Level adds clinical data.	Technical assistance is largely handled through HIEs nationally; states can share provider/contractor technical assistance materials through HIEs as well. Nationwide collaborations streamline assistance to providers/ contractors anywhere in the country. This Level adds nationwide technical interoperability.
VA As Is: There is variation across the state. BHDS and some of the facilities are at Level 1 with some Level 2.	DMAS is at Level 2.	CSBs are at Level 3.		
VA To Be:		Virginia will continue to progress to the next level.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: There is variation across the state.	CSBs and some facilities are at Level 2	Some Level 3 (CSBs/facilitites)		

BHDS and some of the facilities are at Level 1.				
VA To Be:	Virginia will continue to progress to the next level.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: Virginia is at Level 1. BHDS uses CMS audit criteria (CARF), but is not aware of national standards.	Some Level 2.			
VA To Be:	Virginia will continue to progress towards Level 2.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	Virginia is a Level 2 overall.		DMAS' KeyPro authorizations have some Level 4.	
VA To Be:		Virginia will work towards Level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	Some facilities and CSBs are at Level 2 with some Level 3.	BHDS is mostly at a Level 3 with some Level 4.		
VA To Be:	Virginia will continue to progress to the next level.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	Virginia is mostly at	Some Level 3.		

	a Level 2.			
VA To Be:		Virginia will continue to progress to the next level.		

Accountability Management (AM)

AM: Monitor Performance and Business Activity Process				
Item	**Details**			
Description	The ***Monitor Performance and Business Activity*** process utilizes the mechanisms and measures that were developed by the agency. The process includes the steps involved in implementing the mechanisms and measures to track agency activity and effectiveness at all levels. Examples include episodes of care, performance measures, outcomes measures, and quality measures.			
MITA Reference	Source Process Name: *Monitor Performance and Business Activity* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	All Enterprise data State and federal measures		Shared analytical data	
AM: Monitor Performance and Business Activity: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Monitoring activities are primarily done using information from a mix of tape, CD and some proprietary internal systems, using nonstandard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and similar activities may be conducted by different programs. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with other agencies, programs, and data; basic business rules, and enhanced consistency of responses and timing. The process is informed by a set of agency standardized data on clients and services. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared monitoring processes. Monitoring metrics are synchronized across agencies. The process is informed by nationally standardized. Cross agency data is accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	This business process is integrated into monitoring processes through HIEs statewide. This Level adds clinical data.	The process is fully integrated into and interoperable with other local, state, and federal programs with national real time, virtual administrative data access and exchange. This Level adds nationwide technical interoperability.
VA As Is: Facilities range from levels 1-2 with some aspects of level 3.	CSBs are at a level 2 with aspects of level 4, i.e. clinical data.			

VA To Be: Virginia will continue to work towards the next level.				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: Facilities range from levels 1-2 with some aspects of level 3.	CSBs are at a level 2 with aspects of level 3.	Central Office is mostly at level 3 with some aspects of level 2.		
VA To Be: Virginia will continue to work towards the next level. BH would like to move forward with the Electronic Medical Records automation.				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	Facilities are at a level 2.	CSBs are at a level 3.		
VA To Be:	Virginia will continue to work towards the next level.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	Facilities are between levels 2 & 3.	Some CSBs are at a level 3.		
VA To Be:	Virginia will continue to work towards the next level.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	Facilities are		Some CSBs are at a	

	between levels 2 & 3.		level 4.	
VA To Be:	Virginia will continue to work towards the next level.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	Facilities are at a level 2.	Some CSBs are at a Level 3.		
VA To Be:	Virginia will continue to work towards the next level.			

Accountability Management (AM)

AM: Perform Block Grant Reviews Process				
Item	**Details**			
Description	The ***Perform Block Grant Reviews*** process conducts an evaluation of the provider/contractor proposals submitted in response to block grant RFPs. The block grant application process is the formal mechanism for distributing federal block grant funds. The review process involves a team of experts who review and score each proposal. The final score is considered in determining funding allotments.			
MITA Reference	None.			
Sample Data	Block grant proposals Block grant allotment		Review protocols	
AM: Perform Block Grant Reviews: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Review processes are not coordinated among multiple, siloed programs and not systematically connected by agency-wide processes. The review process is primarily manual, using non-standard formats and data. Review requirements may be variable across agencies. The process is often lengthy and inconsistent applied. This Level complies with agency requirements.	Review processes are coordinated with other related programs within the same agency. The process uses Web interfaces; basic business rules; and state agency specific standards. Routine communications are standardized and automated within the agency, and reviews are conducted online. This Level includes additional data and quality edits.	Review processes are coordinated with other health programs in different agencies through interfaces using BH-MITA standardized data that are compatible with Medicaid MITA. The process operates through virtual connections to agency partners; communications and cross agency coordination are standardized. This review process is phased out as the funding/payment and application requirements are aligned with national standards. At this Level data is standardized against HL7 RIM.	Applications are no longer required and the payment process now conforms to industry norms. This process is terminated.	This process is terminated.
VA As Is: Virginia is mostly Level 1.	Some Level 2.			
VA To Be:	Virginia will continue moving towards a full Level 2			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: Virginia is at Level 1				
VA To Be:	Virginia will work towards Level 2.			

Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	Virginia considers itself at Level 2 but notes that block grants come with national standards but are not interfaced. This is largely a paper process. Virginia is not aware of national standards for RFP review.			
VA To Be:	Continue to follow guidelines and standards identified for the process to meet requirements.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	Virginia is at Level 2.			
VA To Be:		Virginia will work toward Level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	Virginia is at Level 2. Client data is limited to aggregate data.			
VA To Be:		Virginia will work towards Level 3.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	Virginia is at a Level			

	2.			
VA To Be:		Virginia will work towards Level 3.		

MITA SS-A Summary

5/24/2011

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(AM) Accountability Management										
Initiate Case	The Initiate Case business process uses criteria and rules to identify patterns or parameters of acceptable/unacceptable behavior, determine when action is needed, and open a case for further investigation. Each type of case is driven by different criteria and rules, different relationships, and different data.									
	2010: The DBHDs entities are functioning mostly at level 1; use of their Avatar system provides some automation. DMAS participants claims functionality in levels 2 and 3.	1	2							
Manage Case	The Manage Case business process receives a case file from an investigative unit with the direction to respond to the case, participate in the case, or pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or client from the program; or the case may be terminated or suspended. 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.									
	2010: DBHDS is mostly level 2 with higher functionality occurring in the areas of Cross Coordination, Client Data and Interoperability.	2	3							

GOVERNOR'S CONFIDENTIAL WORKING PAPERS

MITA SS-A Summary

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Manage Disallowances	The Manage Disallowances process monitors and helps assure provider/contractor compliance with requirements for receiving funding and reimbursement. The process assists providers/contractors in adopting documentation and business practices that support obtaining sufficient and appropriate revenue, and protect them from vulnerability to revenue reductions. Different payers may have different criteria and rules.									
	2010: Functionality varies across the DBHDS entities and MITA qualities with some CSBs and facilities at levels 1 to 3 but generally reach an overall 2. Work will continue to achieve consistency within the organzations.	2	3							
Perform Block Grant Reviews	The Perform Block Grant Reviews process conducts an evaluation of the provider/contractor proposals submitted in response to block grant RFPs. The block grant application process is the formal mechanism for distributing federal block grant funds. The review process involves a team of experts who review and score each proposal. The final score is considered in determining funding allotments.									
	2010: Functions in this area are at a level 2. The lack of national standards and automation for this largely manual effort will keep the agency at this level.	2	3							
Initiate Accreditation	The Initiate Accreditation process provides assistance to providers/contractors in achieving and maintaining the accreditation and credentialing necessary for program participation.									

GOVERNOR'S CONFIDENTIAL WORKING PAPERS

MITA SS-A Summary

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010: DBHDS is mostly level 2 with some aspects of level 3. Most facilities are at a level 2, some have aspects of level 1. However it is noted that this area does not apply to CSBs because of licensing.	2	3							
Monitor Performance and Business Activity	The Monitor Performance and Business Activity process utilizes the mechanisms and measures that were developed by the agency. The process includes the steps involved in implementing the mechanisms and measures to track agency activity and effectiveness at all levels. Examples include episodes of care, performance measures, outcomes measures, and quality measures.									
	2010: Facilities ranged from levels 1 - 2 with some aspects of 3. CSBs are at level 2 with some aspects of level 3, i.e. clinical data.	2	3							
Develop and Manage Performance Measures and Reporting	The Develop and Manage Performance Measures and Reporting business process establishes mechanisms and requirements for developing, managing, and reporting performance measures and other data for providers/contractors, quality, and outcomes, and to comply with state and federal reporting requirements. This process analyzes client and service histories and trends, costs, expenditures, and trends, assesses external factors affecting the program, assesses agency initiatives and plans, identifies significant measurable activities and outcomes, and creates and/or revises performance measures.									
	2010: Facilities are between levels 1 and 2; CSBs are between levels 2 and 3 as some of them have EHRs.	1	2							

GOVERNOR'S CONFIDENTIAL WORKING PAPERS

MITA SS-A Summary

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Conduct Routine Fiscal and Clinical Monitoring	The Conduct Routine Fiscal and Clinical Monitoring business process monitors services, outcomes, and expenditures required to meet state and Federal reporting requirements. The process regularly examines the most current client, service, and provider/contractor data on service delivery and costs, service coverage and improvement, client outcomes, expenditures and other factors as required.									
	2010: Functionality ranges from 1 - 4; CSBs with EHRs function at level 3 for Cross Coordination, Client Data and Interoperability. Some facilities are beetween a 2 and 3.	1	2							

GOVERNOR'S CONFIDENTIAL WORKING PAPERS

Business Relationship Management

Business Relationship Management (BRM)

BRM: Create Block Grant Applications Process				
Item	**Details**			
Description	The ***Create Block Grant Applications*** business process encompasses activities undertaken by the BH agency to solicit provider and contractor applications to provide services.			
MITA Reference	Source Process Name: *Establish Business Relationship* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Standard application template Data from previous applications		Business rules for applications Federal requirements for applications	
BRM: Create Block Grant Applications: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily manual, using nonstandard formats and data. Application formats and requirements may be variable across agencies and require negotiations and involvement of legal counsel. The process is often lengthy and inconsistent in the application of the rules. This Level complies with agency requirements.	The process incorporates direct connectivity across agencies; Web interfaces; basic business rules; and enhanced consistency of process and timing. Application formats and data are standardized within state health agencies, and negotiations are conducted online. Applications creation is more automated, so consistency and completion time is improved. This Level includes additional data and quality edits	The process has virtual access to administrative records and self adjusting business rules. Separate applications formats and data are phased out as the funding/payment and application requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Applications are no longer required and the payment process now conforms to industry norms. This process is terminated.	This process is terminated.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities			

	aspire to level 3.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: Central Office, CSBs, and facilities are at level 1. HIPAA is complied with but otherwise there are only state standards.				
VA To Be: Presently there are no additional national standards to use.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	Central Office, CSBs, and facilities are at level 2.			

VA To Be	Central Office, CSBs, and facilities aspire to level 3.			

Business Relationship Management (BRM)

BRM: Create Business Relationship Process				
Item	**Details**			
Description	The ***Create Business Relationship*** business process encompasses activities undertaken by the State BH agency to enter into a variety of business partner relationships, usually with other government agencies. These arrangements include Memoranda of Understanding (MOUs), interagency contracts and service agreements, health information exchange (HIE) agreements, access and capacity agreements			
MITA Reference	Source Process Name: *Establish Business Relationship* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Standard contract/agreement template Data from previous contract/agreement for same party		Business rules for contracts/agreements Comparable information on other contracts/agreements	
BRM: Prevention: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily manual, using nonstandard formats and data. MOU formats and requirements may be variable across agencies and require negotiations and involvement of legal counsel. The process is often lengthy and inconsistent in the application of the rules. This Level complies with agency requirements.	The process incorporates direct connectivity across agencies; Web interfaces; basic business rules; and enhanced consistency of process and timing. MOU formats and data are standardized within state health agencies, and negotiations are conducted online. MOU creation is more automated, so consistency and completion time is improved. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. MOU formats and data are standardized and automated within all state health agencies, with shared processes for some steps. Rules are consistently applied and legal staff can review and approve online, reducing completion time. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	MOU formats, data and processes are standardized and automated across all government agencies at all levels in the state. The process uses virtual administrative records and integrated systems reduce completion time to the minimum feasible. Standards reduce or eliminate the need for extensive legal review. This Level adds clinical data.	MOU formats and data are standardized and automated across government agencies at all levels nationwide. The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual administrative data access. Completion time is optimized. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is	Central Office is a level 2 with aspects			

	of level 3. CSBs, and facilities are between level 1& 2. For CSBs this is mostly a paper process with some use of email.			
VA To Be	Central Office aspires to level 3 with the use of HL7. CSBs aspire to level 2.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: Central Office, CSBs, and facilities are at level 1. HIPAA is complied with but otherwise there are only state standards.				
VA To Be: Presently there are no additional national standards to use.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Central Office, CSBs, and facilities are at level 2 with internal coordination. There are not externally coordinated.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	This varies by contract, but Central			

	Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			

Business Relationship Management (BRM)

BRM: Create Communications Protocols Process				
Item	**Details**			
Description	The ***Create Communications Protocols*** business process establishes mechanisms and requirements for routine and ad hoc communications between agency business partners. This requirement at present primarily governs communications protocols between substance abuse agencies, child welfare agencies and the courts, where consideration of the confidentiality requirements and legal requirements on all sides is critical to determine what data can be shared. It was noted that this description appears to be out of date because it doesn't reference HIPAA.			
MITA Reference	None			
Sample Data	Communications rules		Confidentiality requirements	
BRM: Create Communications Protocols: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Communications protocols are determined in an ad hoc manner on a case by case basis. Communications are largely sent and received in nonstandard formats, mostly via phone, fax, or USPS. Communications are not coordinated among multiple, siloed programs and not systematically triggered by agencywide processes. This Level complies with agency requirements.	Communications protocols exist and are consistently applied. The process uses Web interfaces; basic business rules; and state agency specific standards. Routine communications are standardized and automated within the agency. This Level includes additional data and quality edits.	The process operates through virtual connections to agency partners. Communications are standardized within the agency and coordination cross agency results in improved efficiencies. Communications protocols are automated as business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Communications protocols are integrated into state HIEs and regular communications are automatic. All health care agencies collaborate in communications between agencies and among all agency partners statewide.	Communications protocols are integrated into HIEs on a national scale. Nationwide collaborations streamline communications with agency partners anywhere in the country. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: This is a case-by-case basis but typically Central Office, CSBs, and facilities are between a level 1 & 2.				
VA To Be: Central Office, CSBs, and facilities aspire to meet level 2.				
Standards				

Level 1	Level 2	Level 3	Level 4	Level 5
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: Central Office, CSBs, and facilities are at level 1. HIPAA is complied with but otherwise there are only state standards.				
VA To Be: Presently there are no additional national standards to use.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Central Office, CSBs, and facilities are at level 2. There is still some faxing done, but the electronic submission capability exists.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems

VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			

Business Relationship Management (BRM)

BRM: Engage in Joint Planning Process				
Item	**Details**			
Description	The ***Engage in Joint Planning*** business process coordinates efforts and programs between agency business partners that have similar goals, objectives, and target populations. Although the goals and objectives may be similar, the specific activities undertaken are often very different but may represent complementary approaches, or comprehensive approaches when combined, to improving client health, treatment, and services.			
MITA Reference	None			
Sample Data	Agency and program goals, objectives, and target populations		Agency and program activities	
BRM: Engage in Joint Planning: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Agency programs, services, and communications are not coordinated among multiple, siloed programs and not systematically connected by agency-wide processes. The planning process is primarily manual, using non-standard formats and data. Program and service requirements may be variable across agencies and difficult to change. The process is often lengthy and produces inconsistent results. This Level complies with agency requirements.	Agency programs, activities, and services are developed and implemented in coordination with other related programs within the same agency. The process uses Web interfaces; basic business rules; and state agency specific standards. Routine communications are standardized and automated within the agency, and negotiations are conducted online. This Level includes additional data and quality edits.	Agency programs, activities, and services are developed and implemented in coordination with other health programs in different agencies. The process operates through virtual connections to agency partners; communications and cross agency coordination are standardized. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Agency programs, activities, and services are coordinated with other related programs among all business partners statewide. Coordination activities and connections across agencies are automated and widely available via HIEs. Additional data is available to augment coordination activities and drive broader planning and service implementation. This Level adds clinical data.	Health programs, activities, and services are coordinated on a national scale using interconnected HIEs. Nationwide collaborations streamline communications with agency partners anywhere in the country. A seamless national care and services network provides optimum care to clients and offers a single point for accessing any type of care and services anywhere in the country. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is	Central Office, CSBs, and facilities are between level 2 & 3 with the exception of HL7 RIM.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Standards				

Level 1	Level 2	Level 3	Level 4	Level 5
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: Central Office, CSBs, and facilities are at level 1.				
VA To Be: Central Office, CSBs, and facilities aspire to level 2.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Central Office, CSBs, and facilities are between level 2 & 3 with the exception of HL7 RIM.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is: Central Office, CSBs, and facilities are at level 1.				
VA To Be: Central Office, CSBs, and facilities aspire to level 2.				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is: Central Office, CSBs, and facilities are at level 1. There is no				

automated interoperability. Planning is ad hoc and intermittent.				
VA To Be: Central Office, CSBs, and facilities aspire to level 2.				

Business Relationship Management (BRM)

BRM: Manage Business Relationship		
Item	**Details**	
Description	The ***Manage Business Relationship*** business process maintains the agreement between the State BH agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards.	
MITA Reference	Source Process Name: *Manage Business Relationship* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Standard agreement template Business rules for type of agreement	Data from previous agreement for same party

BRM: Manage Business Relationship: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using nonstandard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with business partners, basic business rules, and enhanced consistency of responses and timing. Agreement formats and data are standardized within the state. Communications are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Business partner information is accessible to any authorized party through HIEs statewide. Additional business partner data are available for use in this process. This Level adds clinical data.	The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual administrative data access. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards

VA As Is: Central Office, CSBs, and facilities are at level 1.				
VA To Be: Central Office, CSBs, and facilities aspire to level 2.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			

Business Relationship Management (BRM)

BRM: Manage Business Relationship Communications Process				
Item	**Details**			
Description	The ***Manage Business Relationship Communication*** business process produces and assures routine and ad hoc communications between the business partners.			
MITA Reference	Source Process Name: *Manage Business Relationship Communication* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Content for communication			
BRM: Manage Business Relationship Communications: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. Communication is not coordinated among multiple, siloed programs and not systematically triggered by agencywide processes. This Level complies with agency requirements.	The process incorporates Web interfaces; basic business rules; and state agency specific standards. Routine communications with business partners are standardized and automated within the agency. This Level includes additional data and quality edits.	The process operates through virtual access to business partners. Communications are standardized within the agency and coordination cross agency results in improved efficiencies. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Business partner communications are handled through HIEs statewide, and regular communications are automatic. All health care agencies collaborate in communications between agencies and among all business partners statewide. This Level adds clinical data.	Business partner communications are handled through HIEs nationally. Nationwide collaborations streamline communications with business partners anywhere in the country. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is VA As Is:				

Central Office, CSBs, and facilities are at level 1.				
VA To Be: Central Office, CSBs, and facilities aspire to level 2.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is VA As Is: Central Office, CSBs, and facilities are at level 1.				
VA To Be: Central Office, CSBs, and facilities aspire to level 2.				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	Central Office, CSBs, and facilities are at level 2.			
VA To Be	Central Office, CSBs, and facilities aspire to level 3.			

Business Relationship Management (BRM)

BRM: Terminate Business Relationship Process				
Item	**Details**			
Description	The ***Terminate Business Relationship*** business process cancels the agreement between the State BH agency and the business partner.			
MITA Reference	Source Process Name: *Terminate Business Relationship* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Content for response			
BRM: Terminate Business Relationship: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Communications and information exchange for this business process is primarily via paper, telephone, & fax. The process is inconsistent in the application of the rules and in response timing, and uses multiple data formats and semantics. This Level complies with agency requirements.	The process incorporates Web interfaces for business partner agreements; basic business rules; and enhanced consistency of responses and timing. Communications are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	This process is conducted using virtual records through HIEs statewide. Additional business partner data are available for use in this process. This Level adds clinical data.	The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual administrative data access. The process accesses national guidelines and best practices. This Level adds nationwide technical interoperability.
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: Central Office, CSBS and facilities may not renew contracts, but rarely terminate them. There is no automation so this is a level 1.				
VA To Be: There is no need for more automation.				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no	Internal processes	Internal agency	External agency	Non-state entity

national standards	use national standards	processes/interfaces mostly use national standards	processes/interfaces mostly use national standards	processes/interfaces mostly use national standards
VA As Is: Central Office, CSBS and facilities are at a level 1. There are no national standards just state standards in the Procurement Act.				
VA To Be: There are no national standards now.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	This is not done, but if it were it would be a level 2.			
VA To Be	Not applicable			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is: Central Office, CSBS and facilities are at a level 1. No client data is shared. The Business Associate Agreement requires client data to be returned.				
VA To Be: Not applicable				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is: This is not done, but if it were it would be a level 1				
VA To Be: Not applicable				

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(BR) Business Relationship Management										
Manage Business Relationship	The Manage Business Relationship business process maintains the agreement between the State BH agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards.									
	2010: Mostly functioning at a level 2 with the exception of automation.									
Terminate Business Relationship	The Terminate Business Relationship business process cancels the agreement between the State BH agency and the business partner.									
	2010: Mostly functioning at a level 1 with very little automation associated with this process.									
Manage Business Relationship Communication	The Manage Business Relationship Communication business process produces and assures routine and ad hoc communications between the business partners.									
	2010: functioning across levels 1 and 2.									
Create Block Grant Applications	The Create Block Grant Applications business process encompasses activities undertaken by the BH agency to solicit provider and contractor applications to provide services.									
	2010: Mostly functioning at a level 2 with some level 1 occurences among the CBSs, facilities and central office									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Create Business Relationship	The Create Business Relationship business process encompasses activities undertaken by the State BH agency to enter into a variety of business partner relationships, usually with other government agencies. These arrangements include Memoranda of Understanding (MOUs), interagency contracts and service agreements, health information exchange (HIE) agreements, access and capacity agreements									
	2010: Functioning mostly at a level 2.									
Create Communications Protocols	The Create Communications Protocols business process establishes mechanisms and requirements for routine and ad hoc communications between agency business partners. This requirement at present primarily governs communications protocols between substance abuse agencies, child welfare agencies and the courts, where consideration of the confidentiality requirements and legal requirements on all sides is critical to determine what data can be shared. It was noted that this description appears to be out of date because it doesn't reference HIPAA.									
	2010: It was noted that this description appears to be out of date because it doesn't reference HIPAA. Functioning mostly at a level 2.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Engage in Joint Planning	The Engage in Joint Planning business process coordinates efforts and programs between agency business partners that have similar goals, objectives, and target populations. Although the goals and objectives may be similar, the specific activities undertaken are often very different but may represent complementary approaches, or comprehensive approaches when combined, to improving client health, treatment, and services.									
	2010: Functioning mostly at a level 1 with some components of level 2 compliance.									

Care Management

Care Management (CM)

CM: Admit/Enroll Client Process				
Item	**Details**			
Description	The ***Admit/Enroll Client*** business process admits a client to a particular facility and/or enrolls a client in a particular program. The process receives data from the ***Intake Client*** and ***Screening and Assessment*** processes, identifies additional client data needs for admission and enrollment in specific facilities and programs (financial, diagnostic, geographic), sends the data to client and provider/contractor databases or interfaces, and notifies the client and providers/contractors. **NOTE:** There is a separate business process for *Discharge Client*.			
MITA Reference	Source Process Name: *Enroll Member* Source Process Business Area: *Member Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client information		Admitting provider/contractor information	
CL: Admit/Enroll Client: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Client fills out one or more paper forms for various programs and services. This business process is primarily conducted via paper using nonstandard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	Client fills out only one form for various programs and services. The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Data and formats are aligned to conform to national standards. Admission and enrollment processes are standardized and automated within the agency. This Level includes additional data and quality edits.	Admission and enrollment are merged into a single process and coordinated across agencies and programs. The process is fully automated and uses clinical records to assist the admission/ enrollment process. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Admission and enrollment processes are automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and provider/contractor data. Provider/ contractor alerts are fully automated; admission and enrollment information is selfpopulated. This Level adds clinical data.	Admission and enrollment processes are automated through HIEs nationwide. The process automatically verifies the data, designs a client specific service package; and admits/enrolls the client in specific facilities and programs. This Level adds nationwide technical interoperability.
VA As Is: **2010 MITA:** Central Office (Department of Behavioral Health and Developmental Services - DBHDS) is mostly a level 1				

with some level 2 (not HIPAA compliant). CSBs (Community Services Board) are between a level 1 and a level 2.				
VA To Be:	**2010 MITA:** CSBs want to be a solid level 2.	**2010 MITA:** Central Office would like to be a level 3 and ultimately a level 4.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like to be a level 3 and ultimately a level 4.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: **2010 MITA:** CSBs between a level 1 and a level 2. Central Office is a level 1.				
VA To Be:	**2010 MITA:** CSBs would like to be a solid level 2.	**2010 MITA:** Central Office would like to skip level 2 and move right to a level 3.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: **2010 MITA:** CSBs and Central Office are at a level 1.				
VA To Be:	**2010 MITA:**	**2010 MITA:**		

	CSBs would like to be a solid level 2.	Central Office would like to skip level 2 and move right to a level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2010 MITA:** CSBs and Central Office are at a level 2.			
VA To Be:		**2010 MITA:** CSBs would like to move to a level 3 with electronic health records.	**2010 MITA:** Central Office would like to skip level 3 and move to a level 4 with electronic health records.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2010 MITA:** CSBs and Central Office are at a level 2.			
VA To Be:		**2010 MITA:** CSBs would like to move to a level 3 with electronic health records.	**2010 MITA:** Central Office would like to skip level 3 and move to a level 4 with electronic health records.	

Care Management (CM)

CM: Coordinate/Manage Case Process				
Item	**Details**			
Description	The ***Coordinate/Manage Case*** business process uses Federal and State-specific criteria and rules to ensure appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for clients. It includes activities to confirm delivery of services and compliance with the plan, as well as service planning and coordination, brokering of services (finding providers, establishing service limits, etc.), continuity of care, and advocating for the client.			
MITA Reference	Source Process Name: *Manage Case* Source Process Business Area: *Care Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client information Provider/contractor information Payment history Information Service information		Case history Assessment protocol Treatment plan protocol	
CL: Coordinate/Manage Case: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper using non-standard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are non-standard, and are likely statespecific, using statespecific business rules. Care is not coordinated across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to other agencies, programs, and providers/ contractor using Web interfaces; some basic business rules and state agency specific standards are in place. Data and formats are aligned to conform to national standards. Care management processes are standardized and automated within the agency; some coordination occurs. This Level includes additional data and quality edits.	The process is fully automated. Cross agency collaboration results in improved care coordination, and some processes are shared. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and treatment plan data. All care participants are automatically notified and updated when new information is available, and mechanisms are in place to quickly and easily make coordinated and fully informed decisions. This Level adds clinical data.	Care management processes are automated through HIEs nationwide. The process automatically gathers and verifies the data, treatment teams are virtually convened, and decisions made promptly using evidence-based practices. This Level adds nationwide technical interoperability.
VA As Is: **2010 MITA:** Facilities (Department of Behavioral Health and Developmental Services Facilities) at a level 1. CSBs	**2010 MITA:** Central Office is between a level 2 and a level 3 depending on the program.			

(Community Services Board) are between a level 1 and a level 2.				
VA To Be:	**2010 MITA:** CSBs would like to be a solid level 2 and they think they can get there by implementing electronic medical records.	**2010 MITA:** Facilities and Central Office would like to move from a level 1 and 2 to a level 3 by using HL7 and standards.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2010 MITA:** CSBs and Central Office are both at a level 2.			
VA To Be:		**2010 MITA:** Level 3 is the desire for CSBs and Central Office by utilizing HL7 for interfaces.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2010 MITA:** Facilities are at a level 2 and CSBs are between a level 2 and level 3. Not every CSB is CARF accredited.	**2010 MITA:** Central Office is at a level 3. All applications are based on federal reporting requirements, Joint Commission (JC) standards, Part C standards and CMS.		
VA To Be:		**2010 MITA:** CSBs, Facilities and Central Office will continue to use standards and their desire is to move to the next maturity level.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across	Internal agency operational	Internal agency program processes	External agency program and	Non-state entity program and

processes or with other programs	processes coordinated	coordinated	operational processes coordinated	operational processes coordinated
VA As Is:	**2010 MITA:** Central Office is at a level 2. CSBs are between a level 2 and a level 3.			
VA To Be:		**2010 MITA:** Solid level 3 for all parties.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2010 MITA:** CSBs are between a level 2 and a level 3.	**2010 MITA:** Central Office is a level 3.		
VA To Be:			**2010 MITA:** All parties would like to move to a level 4 with external agency processes having access to client specific data.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2010 MITA:** Facilities are between a level 2 and a level 3.	**2010 MITA:** Central Office and CSBs are at a level 3.		
VA To Be:			**2010 MITA:** Electronic health records will move everyone to the next level.	

Care Management (CM)

CM: Develop Discharge Planning and Aftercare Plan Process				
Item	**Details**			
Description	The ***Develop Discharge Planning and Aftercare Plan*** business process uses Federal and State-specific criteria, rules, best practices and professional judgment to develop discharge planning and aftercare plans that optimize successful outcomes. It includes activities to track and assess the client and his/her treatment progress during the episode of care and status at discharge, evaluate client needs for ongoing care and support services, and establish a long term plan for continuing and/or sustaining recovery.			
MITA Reference	None.			
Sample Data	Client information Provider/contractor information Payment history Information Service information		Case history Assessment protocol Treatment plan protocol	
CL: Develop Discharge Planning and Aftercare Plan: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper, phone, and fax using nonstandard forms and data. The process is inconsistent in approach and timing. Format and content are nonstandard, and are likely state-specific, using state-specific business rules. Discharge/aftercare plan development is not coordinated across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to other agencies, programs, and providers/ contractors using Web interfaces to facilitate development; some basic business rules and state agency specific standards are in place. Data and formats are aligned to conform to national standards. Discharge/aftercare plan development processes are standardized and automated within the agency; some coordination occurs. This Level includes additional data and quality edits.	The process is fully automated. Cross agency collaboration results in improved coordination of discharge/aftercare plan development activities; some processes are shared. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and treatment plan data. Plan participants are automatically notified when the client is ready to discharge, and mechanisms are in place to quickly and easily track client progress and status to develop appropriate discharge/aftercare plans. This Level adds clinical data.	Discharge/aftercare plan development processes are automated through HIEs nationwide. The process automatically gathers and verifies the data, teams are virtually convened, and decisions made promptly using evidence-based practices. Continuous tracking allows real time adjustment of discharge/aftercare goals to maximize successful recovery. This Level adds nationwide technical interoperability.
VA As Is: **2010 MITA:** Central Office (Department of Behavioral Health and Developmental Services – DBHDS) is at a level 1 because they do not				

use national standards at this point. CSBs (Community Services Board) between a level 1 and a level 2.				
VA To Be:	**2010 MITA:** CSBs would like to be a solid level 2 with electronic medical records.	**2010 MITA:** Central Office would like to skip level 2 and move to a level 3 with electronic medical records.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2.			
VA To Be:		**2010 MITA:** CSBs would like to be a level 3 with electronic medical records.	**2010 MITA:** Central Office would like to skip level 3 and move to a level 4 with electronic medical records.	
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: **2010 MITA:** CSBs and Central Office are at a level 1.				
VA To Be:	**2010 MITA:** CSBs would like to be a solid level 2 with electronic medical records.	**2010 MITA:** Central Office would like to skip level 2 and move to a level 3 with electronic medical records.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: **2010 MITA:** Central Office is at a	**2010 MITA:** CSBs are at a level 2.			

level 1.				
VA To Be:		**2010 MITA:** All parties would like to move to a level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2.			
VA To Be:		**2010 MITA:** CSBs would like to be a level 3 with electronic medical records.	**2010 MITA:** Central Office would like to skip level 3 and move to a level 4 with electronic medical records.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like to be a level 3 with electronic medical records.		

Care Management (CM)

CM: Develop Treatment Plan, Goals, Methods and Outcomes Process				
Item	**Details**			
Description	The ***Develop Treatment Plan Goals, Methods, Outcomes*** business process uses Federal and State-specific criteria, rules, best practices and professional judgment to develop client treatment plans that optimizes successful outcomes. It includes involving a team of professionals to engage in activities to track and assess the client and his/her treatment progress both on intake and throughout the care process, establish and adapt a care plan tailored to changing client needs, and establish achievable goals and an appropriate mix of treatment and support services.			
MITA Reference	None.			
Sample Data	Client information Provider/contractor information Payment history Information Service information		Case history Assessment protocol Treatment plan protocol	
CL: Develop Treatment Plan, Goals, Methods and Outcomes: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper, phone, and fax using nonstandard forms and data. The process is inconsistent in approach and timing. Format and content are nonstandard, and are likely state-specific, using state-specific business rules. Treatment plan development is not coordinated across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to other agencies, programs, and providers/ contractors using Web interfaces to facilitate development; some basic business rules and state agency specific standards are in place. Data and formats are aligned to conform to national standards. Treatment plan development processes are standardized and automated within the agency; some coordination occurs. This Level includes additional data and quality edits.	The process is fully automated. Cross agency collaboration results in improved coordination of treatment plan development activities; some processes are shared. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and any previous treatment plan data. All care participants are automatically notified and updated when new information is available, and mechanisms are in place to quickly and easily track progress and make informed changes to the treatment plan. This Level adds clinical data.	Treatment plan development processes are automated through HIEs nationwide. The process automatically gathers and verifies the data, treatment teams are virtually convened, and decisions made promptly using evidence-based practices. Continuous tracking allows real time adjustment of treatment goals to maximize successful outcomes. This Level adds nationwide technical interoperability.
VA As Is: **2010 MITA:** Central Office (Department of Behavioral Health and Developmental Services – DBHDS) is at a level 1.				

CSBs (Community Services Board) are between a level 1 and a level 2.				
VA To Be:	**2010 MITA:** CSBs aim to be at a solid level 2 with the use of electronic medical records.		**2010 MITA:** Central Office aim to be a level 4 by 2014.	
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **2010 MITA:** Central Office and Facilities are between a level 1 and a level 2.	**2010 MITA:** CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like to be at a level 3 with the implementation of electronic health records.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: **2010 MITA:** Central Office is at a level 1.	**2010 MITA:** CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like to be at a level 3 with the implementation of electronic health records.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: **2010 MITA:** Central Office is a level 1. CSBs are				

between a level 1 and a level 2.				
VA To Be:	**2010 MITA:** CSBs would like to be a solid level 2.	**2010 MITA:** Central Office would like to move to a level 3 with electronic medical records.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2010 MITA:** CSBs and Central Office are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like to be a level 3.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2010 MITA:** CSBs and Central Office are at a level 2.			
VA To Be:		**2010 MITA:** CSBs would like to be a level 3.	**2010 MITA:** Central Office would like to move to a level 4 with electronic health records.	

Care Management (CM)

CM: Discharge Client Process				
Item	**Details**			
Description	The ***Discharge Client*** business process is responsible for managing the termination of a client's stay in a facility or participation in a program, for any reason. The process uses data from the *Admit/Enroll Client* process and from client data and records gathered throughout the period of service, validates the discharge data, loads or sends the data into the Client and Provider/Contractor databases or interfaces, loads or sends the data to billing systems for payment, and produces notifications for providers/contractors and for reporting purposes. **NOTE:** There is a separate business process for *Admit/Enroll Client*.			
MITA Reference	Source Process Name: *Disenroll Member* Source Process Business Area: *Member Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client information Service information		Discharging provider/contractor information	
CL: Discharge Client: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper using non-standard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Data and formats are aligned to conform to national standards. Discharge processes are standardized and automated within the agency. This Level includes additional data and quality edits.	The process is fully automated. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and provider/contractor data. Provider/ contractor alerts are fully automated; discharge information is selfpopulated. This Level adds clinical data.	Discharge processes are automated through HIEs nationwide. The process automatically gathers and verifies the data, and discharges the client from specific facilities and programs. This Level adds nationwide technical interoperability.
VA As Is: **2010 MITA:** Central Office (Department of Behavioral Health and Developmental Services – DBHDS)and CSBs (Community Services Board) are at a level 1.				
VA To Be:		**2010 MITA:**		

		All parties would like to be at a level 3 but ultimately at a level 4. Electronic health records should move this to the next level.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **2010 MITA:** Facilities and Central Office are between a level 1 and a level 2.	**2010 MITA:** CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like to move to a level 3 with electronic health records.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: **2010 MITA:** Central Office is at a level 1. They are not using national standards. CSBs are between a level 1 and a level 2. Not all CSBs are CARF accredited.				
VA To Be:	**2010 MITA:** All parties would like to use national standards for their processes.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2.			

VA To Be:			**2010 MITA:** All parties would like the use of electronic medical records for cross coordination purposes.	
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2.			
VA To Be:			**2010 MITA:** Central Office is aiming to have consumers access data in the future.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2. Some CSBs are a little in level 3.			
VA To Be:		**2010 MITA:** CSBs would like to be at a solid level 3 with the use of electronic medical records.	**2010 MITA:** Central Office would like to be at a level 4 with the use of electronic medical records.	

Care Management (CM)

CM: Intake Client Process				
Item	**Details**			
Description	The ***Intake Client*** business process receives intake data from the client; checks for status (e.g., new, current, past), establishes type of client (e.g., pregnant, IV drug user, HIV positive, other); opens a client file; screens for required fields, edits required fields, verifies client information with external entities if available, and assigns an ID.			
MITA Reference	Source Process Name: *Establish Case* Source Process Business Area: *Care Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client, provider, and service history data Assessment protocols	Treatment Plan protocol Table of available providers		
CL: Intake Client: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Client fills out one or more paper forms for various programs and services. This business process is primarily conducted via paper using nonstandard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	Client uses only one form for all programs and services. The process incorporates Web interfaces for intake; accesses client, provider/contractor and service information; uses basic business rules and state agency specific standards. Intake data and formats conform to standards, and basic intake processes are standardized and automated within the agency. This Level includes additional data and quality edits.	The process is fully automated; uses self adjusting business rules; and uses some clinical data to augment the intake process. Cross agency collaboration results in a one-stop shop, with some shared intake processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Intake is embedded in provider/ contractor/agency communications through statewide HIEs, eliminating the need for most human intervention. The process has automated access to virtual records and a broad spectrum of clinical data statewide to quickly verify intake information. This Level adds clinical data.	Inter-enterprise business process management between all state health agency systems nationwide and real time connectivity eliminates the need for most intake processes. Intake is automated using real time access to client data. This Level adds nationwide technical interoperability.
VA As Is: **MITA 2010:** Facilities (Department of Behavioral Health and Developmental Services - DBHDS) mostly use paper and can not access CSB (Community	**MITA 2010:** CSBs are mostly operating at a level 2.			

Services Board) records electronically.				
VA To Be:		**MITA 2010:** Facilities and CSBs would like automation and use of Electronic Medical records.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **MITA 2010:** Facilities are mostly paper.	**MITA 2010:** CSBs are mostly at level 2 with some CSBs at a level 3.			
VA To Be:		**MITA 2010:** Facilities would like to advance from a level 1 to a level 3 by using electronic health records.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**MITA 2010:** Facilities use Joint Commission Standards (JC) and CMS standards. CSBs use CARF.			
VA To Be:	**MITA 2010:** Working to fully function at Level 2. More standards will help achieve the movement to a level 2.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**MITA 2010:** Facilities are operating at level 2 with processes defined. CSBs are			

	between a level 2 and a level 3.			
VA To Be:	**MITA 2010:** Facilities would like to use treatment plans and electronic health records to move to a level 3. CSBs would like to expand the use of electronic medical records to move to a level 3.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**MITA 2010:** Facilities have internal access to text base materials in house. CSBs are between a level 2 and a level 3.			
VA To Be:	**MITA 2010:** CSBs would like to share client data consistently to move to a full level 3. Facilities would like the use of electronic health records to move to level 3.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**MITA 2010:** Facilities are at a level 2.	**MITA 2010:** CSBs are at a level 3.		
VA To Be:	**MITA 2010:** Facilities would like to advance to a level 4 with the use of electronic health records.			

Care Management (CM)

CM: Manage and Monitor Client and Treatment Outcomes Process				
Item	**Details**			
Description	The ***Manage and Monitor Client and Treatment Outcomes*** business process uses Federal and State-specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes client and client population outcomes. It includes activities to track and assess effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. It also includes ongoing monitoring, management, and reassessment of services and treatment plans for need, appropriateness, and effectiveness, and monitoring of special client populations (block grant, pregnant women and children, and HIV/intravenous drug users).			
MITA Reference	None.			
Sample Data	Client information Provider/contractor information Payment history Information Service information		Case history Assessment protocol Treatment plan protocol	
CL: Manage and Monitor Client and Treatment Outcomes: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper using non-standard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are non-standard, and are likely state specific, using state specific business rules. Monitoring and outcomes are not coordinated across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to other agencies, programs, and providers/ contractors using Web interfaces; some basic business rules and state agency specific standards are in place. Data and formats are aligned to conform to national standards. Monitoring and outcomes processes are standardized and automated within the agency; some coordination occurs. This Level includes additional data and quality edits.	The process is fully automated. Cross agency collaboration results in improved monitoring and outcomes coordination, and some processes are shared. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and treatment plan data. All care participants are automatically notified and updated when new information is available, and mechanisms are in place to quickly and easily track progress and make informed adjustments. This Level adds clinical data.	Care management processes are automated through HIEs nationwide. The process automatically gathers and verifies the data, treatment teams are virtually convened, and decisions made promptly using evidence-based practices. Continuous tracking allows real time adjustment of agency and treatment goals for improving care practices. This Level adds nationwide technical interoperability.
VA As Is: **2010 MITA:** Central Office (Department of Behavioral Health and Developmental Services – DBHDS)				

is mostly at a level 1. CSBs (Community Services Board) are between a level 1 and a level 2.				
VA To Be:		**2010 MITA:** All parties would like the use of electronic medical records to move this to a level 3.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **2010 MITA:** Central Office is mostly at a level 1 with some level 2. CSBs are between a level 1 and a level 2, and Facilities are at a level 1.				
VA To Be:		**2010 MITA:** All parties would like the use of electronic medical records to move this to a level 3.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: **2010 MITA:** Central Office is at a level 1. CSBs are between a level 1 and a level 2.				
VA To Be:		**2010 MITA:** All parties would like the use of electronic medical records to move this to a level 3.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with	Internal agency operational processes	Internal agency program processes coordinated	External agency program and operational	Non-state entity program and operational

other programs	coordinated		processes coordinated	processes coordinated
VA As Is: **2010 MITA:** Central Office is at a level 1. CSBs are between a level 1 and a level 2.				
VA To Be:	**2010 MITA:** CSBs would like to move to a solid level 2 with the use of electronic medical records.	**2010 MITA:** Central Office would like the use of electronic medical records to move this to a level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like the use of electronic medical records to move this to a level 3.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2010 MITA:** Central Office and CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like the use of electronic medical records to move this to a level 3.		

Care Management (CM)

CM: Manage Wait List				
Item	**Details**			
Description	The ***Manage Wait List*** business process receives data from the **client**; registers type of client (e.g., pregnant, IV drug user, HIV positive, other), client service type needs (mental health, substance abuse), and registers preferred facilities and programs; screens for required fields, edits required fields, verifies client information with external data if available, and assigns an ID. Data is stored and then retrieved as openings occur in the appropriate facilities and programs.			
MITA Reference	None.			
Sample Data	Client information		Intake provider/contractor information	
CL: Manage Wait List: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper using non-standard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to providers/ contractors; Web interfaces for wait list notifications; and state agency specific standards. Business rules including a priority level/ hierarchy of need are applied. Wait list data and formats are standardized, and processes are standardized and automated within the agency. This Level includes additional data and quality edits.	The process is fully automated; uses client data to identify appropriate services, with automatic alerts of appropriate openings for wait listed clients. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Business rules and priority level/ hierarchy are automated. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	All wait list processes are automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and provider/contractor data for tracking service specific openings. Alerts for available openings are fully automated; intake information is self-populated. This Level adds clinical data.	All wait list processes are automated through HIEs nationwide, full interoperability with other local, state, and federal programs, and access to all providers/ contractors nationally. This Level adds nationwide technical interoperability.
VA As Is: **MITA 2010:** CSBs (Community Services Board) and Facilities (Department of Behavioral Health and Development Services – DBHDS) are at a level 1.				
VA To Be: **MITA 2010:** Electronic health				

records and connection to a HIE will move this maturity level up.				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **MITA 2010:** Facilities are at a level 1.	**MITA 2010:** CSBs are at a level 2.			
VA To Be: **MITA 2010**: The use of Electronic health records will move this to the next level.	**MITA 2010**: The use of Electronic health records will move this to the next level.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: **MITA 2010:** Facilities are between a level 1 and 2.	**MITA 2010:** CSBs are between a level 2 and 3.			
VA To Be: **MITA 2010:** The use of more standards will move this to the next level.	**MITA 2010:** The use of more standards will move this to the next level.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: **MITA 2010:** Facilities are between a level 1 and 2.	**MITA 2010:** CSBs are between a level 2 and 3.			
VA To Be: **MITA 2010**: The use of Electronic health records will move this to the next level.	**MITA 2010**: The use of Electronic health records will move this to the next level.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**

Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**MITA 2010:** CSBs and Facilities are between a level 2 and 3.			
VA To Be:	**MITA 2010**: The use of Electronic health records will move this to the next level.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**MITA 2010:** Facilities are at a level 2.	**MITA 2010:** CSBs are at a level 3.		
VA To Be:	**MITA 2010**: The use of Electronic health records will move this to the next level.	**MITA 2010**: The use of Electronic health records will move this to the next level.		

Care Management (CM)

CM: Prevention Process				
Item	**Details**			
Description	The ***Prevention*** business process provides training, education and support to vulnerable populations to assist in preventing individuals from engaging in harmful behaviors and provide support for recovering clients.			
MITA Reference	None.			
Sample Data	Population health data Accountability and quality measure data Service data: Services and provider types; program policy; and provider/ contractor information		Client demographics Client social, functional, clinical, and financial data Provider/contractor data, such as type, location, language, availability.	
CL: Prevention: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Prevention information and activities are manually prepared, updated, and delivered. Agencies use TV, radio, and newspaper advertisements to distribute information. Prevention across multiple, siloed programs is uncoordinated, and linguistic and cultural sensitivity is lacking. Quality and consistency of prevention efforts is variable. This Level complies with agency requirements.	Increased use of agency standards for prevention approaches improves delivery and better meets cultural and linguistic needs. Linguistically, culturally, and competency appropriate information and delivery requires significant manual intervention. Electronic information is available via a Web portal. Standard prevention information is maintained and distributed to individuals and providers/ contractors via electronic media. This Level includes additional data and quality edits.	Prevention information is available via state Web portals using BH-MITA and MITA standard data and interfaces and is coordinated with other collaborating agencies. Automated translation and repositories of cultural and competency appropriate information facilitates prevention activities. Prevention information is also delivered interactively online. At this Level data is standardized against HL7 RIM.	Prevention information and activities are facilitated through HIEs statewide; some activities are triggered automatically. All health care agencies collaborate in prevention information and activities statewide. Clinical and administrative information can automatically trigger prevention information to be sent to the provider/ contractor. This Level adds clinical data.	Prevention information and activities are facilitated through HIEs nationally. Nationwide collaborations streamline prevention information and activities and supports best practices throughout the country. This Level adds nationwide technical interoperability.
VA As Is: **2010 MITA:** CSBs (Community Services Board) and Central Office (Department of Behavioral Health and Developmental				

Services – DBHDS) are at a level 1. The team would like to note there is not a lot of advertising going on outside of individual providers educating the recipients. Facilities and CSBs discuss 'Prevention' as part of the treatment plan, during the administration of a particular program such as Early Intervention and at the time of discharge. *Note: Most prevention occurs one-on-one.				
VA To Be:	**2010 MITA:** All parties would like to move to a level 2 and ultimately skip to a level 3.			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **2010 MITA:** CSBs are at a level 1.	**2010 MITA:** Central Office is at a level 2. Central Office leverages existing data to help in prevention activities.			
VA To Be:		**2010 MITA:** All parties would like to move to a level 3.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: **2010 MITA:** CSBs and Central Office are at a level 1.				
VA To Be:	**2010 MITA:** All parties would like			

	to move to a level 2.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: **2010 MITA:** CSBs and Central Office are at a level 1.				
VA To Be:	**2010 MITA:** All parties would like to move to a level 2 and ultimately move to a level 3.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is: **2010 MITA:** Central Office is between a level 1 and a level 2.	**2010 MITA:** CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like to move to a level 3.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is: **2010 MITA:** Central Office is between a level 1 and a level 2.	**2010 MITA:** CSBs are at a level 2.			
VA To Be:		**2010 MITA:** All parties would like to move to a level 3.		

Care Management (CM)

CM: Referral/Placement Process				
Item	**Details**			
Description	The ***Referral/Placement*** business process is used to refer or assign clients to specific providers for particular services. Examples are referrals by the BH agency to physicians or other providers for medical care, rehab, counseling, or other support services (transportation, employment assistance, child care, housing). This process is also used by providers/contractors to make follow up referrals for services. **Placement** closely follows the details of the Referral process and may not require a separate business process definition.			
MITA Reference	Source Process Name: *Authorize Referral* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client information Referred to provider/contractor Information		Referred from provider/contractor information	
CL: Referral/Placement: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper using non-standard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Referral data and formats are aligned to conform to the HIPAA standard, X12 278. Referral processes are standardized and automated within the agency. This Level includes additional data and quality edits.	Referral and placement are merged into a single process and coordinated across agencies and programs. The process is fully automated. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The referral and placement processes are automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and provider/contractor data. Provider/ contractor alerts are fully automated; referral and placement information is selfpopulated. This Level adds clinical data.	The referral and placement process is automatically triggered by point of service applications and communicated through HIEs nationwide. The process automatically alerts providers/ contractors, initiates the admission and enrollment process; and assigns and schedules appointments and services. This Level adds nationwide technical interoperability.
VA As Is: **MITA 2010:** Facilities (Department of Behavioral Health and Developmental Services – DBHDS Facilities) and CSBs (Community Services Board) are at a level 1.				
VA To Be:				

MITA 2010: Facilities and CSBs would like to advance to a level 3 with the use of electronic health records.				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **MITA 2010:** Facilities are at a level 1.	**MITA 2010:** CSBs are at a level 2 with their use of master treatment plans.			
VA To Be: **MITA 2010:** Facilities would like the use of common data sets along with common standards to move to level 2.	**MITA 2010:** CSBs and Facilities would like the use of electronic records to move forward. The exchange of data will occur easier. HIEs will move this forward.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**MITA 2010:** Facilities and CSBs are at a level 2 with the use of CARF, Joint Commission and CMS.			
VA To Be:	**MITA 2010:** More standards will move this to the next level.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**MITA 2010:** Facilities and CSBs are at a level 2.			
VA To Be:	**MITA 2010:** The use of electronic health records will move this forward to the next level.			

Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**MITA 2010:** Facilities are at a level 2.	**MITA 2010:** CSBs are at a level 3.		
VA To Be:	**MITA 2010:** The use of electronic health records will move this forward to the next level.	**MITA 2010:** The use of electronic health records will move this forward to the next level.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**MITA 2010:** Facilities are at a level 2.	**MITA 2010:** CSBs are at a level 3.		
VA To Be:	**MITA 2010:** The use of electronic health records will move this forward to the next level.	**MITA 2010:** The use of electronic health records will move this forward to the next level.		

Care Management (CM)

CM: Screening and Assessment Process				
Item	**Details**			
Description	The ***Screening and Assessment*** business process receives response data from the **client,** and assesses for certain health and behavioral health conditions (chronic illness, mental health, substance abuse), lifestyle and living conditions (employment, religious affiliation, living situation) to determine risk factors, establishes risk categories and hierarchy, severity, and level of need; screens for required fields, edits required fields, verifies information from external sources if available, establishes severity scores and diagnoses, and associates with applicable service needs.			
MITA Reference	None.			
Sample Data	Client information Client health and lifestyle information		Screening and assessment questions Assessment protocols	
CL: Screening and Assessment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Client fills out one or more paper forms for various programs and services. This business process is primarily conducted via paper using nonstandard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	Client uses only one form for all programs and services. The process incorporates Web interfaces for some standardized electronic screening and assessment tools; accesses provider/contractor and service information; uses basic business rules and state agency specific standards. Screening and assessment data and formats conform to standards, and basic screening and assessment processes are standardized and automated within the agency. This Level includes additional data and quality edits.	The process is fully automated; uses self adjusting business rules; and uses some clinical data to verify and prepopulate responses. Uses only standardized automated screening and assessment tools. Cross agency collaboration results in a one-stop shop, with some shared screening and assessment processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process has automated access to virtual records and a broad spectrum of clinical data through statewide HIEs to verify and selfpopulate selected responses. Standardized automated screening tools are available to providers via the network. This Level adds clinical data.	All screening and assessment processes are automated through HIEs nationwide, with full interoperability with other local, state, and federal programs, and access to all client clinical and administrative data. Real time access to client data can selfpopulate screening and assessment tools when sufficient current client data is available. This Level adds nationwide technical interoperability.
VA As Is: **MITA 2010:** Facilities (Department of Behavioral Health and Developmental Services – DBHDS) are at a level 1.	**MITA 2010:** CSBs are between a level 2 and a level 3.			
VA To Be:	**MITA 2010:** CSBs would like more			

MITA 2010: Facilities would like electronic automation and connectivity to the CSBs (Community Services Board) to be able to share as much information as possible to move to the next level.	standards to move to level 3.			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **MITA 2010:** Facilities are between a level 1 and a level 2.	**MITA 2010:** CSBs are between a level 2 and a level 3.			
VA To Be: **MITA 2010:** Facilities would like to fully move to a level 2 in automation.	**MITA 2010:** CSBs would like to fully move to a level 3 in automation.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**MITA 2010:** Facilities are using Joint Commission (JC) standards as well as CMS standards. CSBs use CARF.			
VA To Be:	**MITA 2010:** Facilities and CSBs would like to continue to improve their standards to move to a level 3.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**MITA 2010:** Facilities and CSBs			

	are at a level 2.			
VA To Be:	**MITA 2010:** The use of Electronic health records will advance CSBs and Facilities to the next level.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**MITA 2010:** Facilities use AVATAR and are at a level 2.	**MITA 2010:** CSBs are between a level 3 and a level 4.		
VA To Be:	**MITA 2010:** Facilities would like to move to a level 3 by automating and using electronic health records.	**MITA 2010:** CSBs would like to move to a level 4 by automating and using electronic health records.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**MITA 2010:** Facilities and CSBs are at a level 2.			
VA To Be:	**MITA 2010:** Facilities and CSBs would like electronic health records to move to the next level.			

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(CM) Care Management										
Discharge Client	**Description:** The Discharge Client business process is responsible for managing the termination of a client's stay in a facility or participation in a program, for any reason. The process uses data from the Admit/Enroll Client process and from client data and records gathered throughout the period of service, validates the discharge data, loads or sends the data into the Client and Provider/Contractor databases or interfaces, loads or sends the data to billing systems for payment, and produces notifications for providers/contractors and for reporting purposes. NOTE: There is a separate business process for Admit/Enroll Client.									
	2010: Functioning between level 1 and 2 for the CBS and facilities; some of the CSBs are functioning at a level 2 for	1	2							Y
Coordinate/Manage Case	Description: The Coordinate/Manage Case business process uses Federal and State-specific criteria and rules to ensure appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for clients. It includes activities to confirm delivery of services and compliance with the plan, as well as service planning and coordination, brokering of services (finding providers, establishing service limits, etc.), continuity of care, and advocating for the client.									
	2010: Most functions are at a level 2 with some level 3 compliance minus the use of HL7 standards. Looking to achieve level 3 and beyond with use of EHRs and use of standards.	2	3							**Y**

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Intake Client	Description: The Intake Client business process receives intake data from the client; checks for status (e.g., new, current, past), establishes type of client (e.g., pregnant, IV drug user, HIV positive, other); opens a client file; screens for required fields, edits required fields, verifies client information with external entities if available, and assigns an ID.									
	2010: DBHDS CO, CSBs and facilites are at level 2 ; would like to expand and/or implement use of EMRs to function at a higher level.	2	3							**Y**
Referral/Placement	Description: The Referral/Placement business process is used to refer or assign clients to specific providers for particular services. Examples are referrals by the BH agency to physicians or other providers for medical care, rehab, counseling, or other support services (transportation, employment assistance, child care, housing). This process is also used by providers/contractors to make follow up referrals for services. Placement closely follows the details of the Referral process and may not require a separate business process definition.									
	2010: Facilities and CSB are mostly at a level 2; some CSBs are functioning at a level 3 for client data and interoperability. Still needs to incorporate more standards.	2	3							**Y**

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Develop Discharge Planning and Aftercare Plan	Description: The Develop Discharge Planning and Aftercare Plan business process uses Federal and State-specific criteria, rules, best practices and professional judgment to develop discharge planning and aftercare plans that optimize successful outcomes. It includes activities to track and assess the client and his/her treatment progress during the episode of care and status at discharge, evaluate client needs for ongoing care and support services, and establish a long term plan for continuing and/or sustaining recovery.									
	2010: Facilities and CSB are mostly at a level 2; some CSBs are functioning at a level 3 for client data and interoperability. Still needs to incorporate more standards.	2	3							Y
Screening and Assessment	Description: The Screening and Assessment business process receives response data from the client, and assesses for certain health and behavioral health conditions chronic illness, mental health, substance abuse), lifestyle and living conditions (employment, religious affiliation, living situation) to determine risk factors, establishes risk categories and hierarchy, severity, and level of need; screens for required fields, edits required fields, verifies information from external sources if available, establishes severity scores and diagnoses, and associates with applicable service needs.									
	2010: Facilities and CSBs are mostly at a level 2; working to develop more automation and use of standards to move to a level 3.	2	3							Y

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Prevention	Description: The Prevention business process provides training, education and support to vulnerable populations to assist in preventing individuals from engaging in harmful behaviors and provide support for recovering clients.									
	2010: (NOTE: CSBs (Community Services Board) and Central Office (Department of Behavioral Health and Developmental Services – DBHDS) are at a level 1. The team would like to note there is not a lot of advertising going on outside of individual providers educating the recipients. Facilities and CSBs discuss 'Prevention' as part of the treatment plan, during the administration of a particular program such as Early Intervention and at the time of discharge. Most prevention occurs one-on-one.) Functioning at a level 1; aspiring to level 2.	1	2							Y
Admit/Enroll Client	Description: The Admit/Enroll Client business process admits a client to a particular facility and/or enrolls a client in a particular program. The process receives data from the Intake Client and Screening and Assessment processes, identifies additional client data needs for admission and enrollment in specific facilities and programs (financial, diagnostic, geographic), sends the data to client and provider/contractor databases or interfaces, and notifies the client and providers/contractors. NOTE: There is a separate business process for Discharge Client.									

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010: Functioning between level 1 and 2 for the CBS and facilities; some of the CSBs are functioning at a level 2 for Automation, Client Data and Interoperability. All 3 DBHDs entities would like to reach level 3 with EHRs.	1	2							Y
Develop Treatment Plan Goals, Methods, and Outcomes	Description: The Develop Treatment Plan Goals, Methods, Outcomes business process uses Federal and State-specific criteria, rules, best practices and professional judgment to develop client treatment plans that optimizes successful outcomes. It includes involving a team of professionals to engage in activities to track and assess the client and his/her treatment progress both on intake and throughout the care process, establish and adapt a care plan tailored to changing client needs, and establish achievable goals and an appropriate mix of treatment and support services.									
	2010: The DBHDS CO and facilites are functioning mostly at a level 1 while most CSBs are consistently functioning at a level 2. They have goals to use automation to reach levels 3 and 4.	1	2							Y
Manage Wait List	Description: The Manage Wait List business process receives data from the client; registers type of client (e.g., pregnant, IV drug user, HIV positive, other), client service type needs (mental health, substance abuse), and registers preferred facilities and programs; screens for required fields, edits required fields, verifies client information with external data if available, and assigns an ID. Data is stored and then retrieved as openings occur in the appropriate facilities and programs.									

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010: Functioning between level 1 and 2 for the CBS and facilities. Woking towards EMR to move to achieve level 2, 3 and beyond.	1	2							Y
Manage and Monitor Client and Treatment Outcomes	Description: The Manage and Monitor Client and Treatment Outcomes business processuses Federal and State-specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes client and client population outcomes. It includes activities to track and assess effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. It also includes ongoing monitoring, management, and reassessment of services and treatment plans for need, appropriateness, and effectiveness, and monitoring of special client populations (block grant, pregnant women and children, and HIV/intravenous drug users).									
	2010: All DBHDS are functioning at a level 1 for this process. Would like to achieve level 3 competency with EMRs/EHRs, automation and standards.	2	3							Y

Client Management

Client Management (CL)

CL: Inquire Client Information Process				
Item	**Details**			
Description	The ***Inquire Client Information*** business process receives requests for client information from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set. The client database includes demographic, financial, socio-economic, treatment, service, health status, and outcomes information.			
MITA Reference	Source Process Name: *Inquire Provider Information* Source Process Business Area: *Provider Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client information and history databases Referral and placement information	Client grievances/appeals Client communications history		
CL: Inquire Client Information: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. This Level complies with agency requirements.	Inquiries about clients are communicated in a standard format. The process incorporates direct connectivity to agency programs and provider/ contractors; Web interfaces for inquiries; basic business rules; and state agency specific standards. Routine inquiries for client information are standardized and automated within the agency. This Level includes additional data and quality edits.	Inquiries about clients incorporate national data standards, and results are standard, consistent and more accurate. The process has virtual access to client data. Cross agency collaboration results in a one-stop shop, with information accessible to external partners and clients via the Web. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Client databases are federated with HIEs statewide so that any authorized stakeholder can request client specific clinical information. Client health record locator services are integrated into HIEs to enhance responses to inquiries regarding clients. This Level adds clinical data.	Client information is federated with HIEs nationally so that any stakeholder can request provider/contractor information to the extent authorized anywhere in the country. This Level adds nationwide technical interoperability.
VA As Is 2010: All Facilities at Level 1. Mostly a manual process.				
	VA To Be 2010: All Facilities would like to move towards standardizing automation and Level 2.			
Automation				

Level 1	Level 2	Level 3	Level 4	Level 5
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is 2010: Mostly Level 1 manual/paper processes occurring.	**VA As Is 2010:** Some internal processes are automated in some Facilities. Would like to automate interfaces between one another.			
	VA To Be 2010: All Facilities would like to move towards Level 2 processes.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is 2010: All Facilities operating at Level 1. Not using HL7 at this time.				
	VA To Be 2010: All Facilities would like more automation and the use of national standards for their processes.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is 2010: All Facilities operating at Level 1. Not much coordination between programs occurring at this level.				
	VA To Be 2010: All Facilities would like more automation and more coordinated			

	processes.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is 2010: Most Facilities are operating at a Level 1 with some access to client specific data.	**VA As Is 2010:** Some Facilities are utilizing shared databases.			
	VA To Be 2010: All Facilities would like to move forward to Level 2. The HIE is needed to move this forward.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
	VA As Is 2010: Most Facilities are operating at a Level 2 by being able to access databases (with proper security authority) across Facilities.	**VA As Is 2010:** Some Level 3 functionalities exist but still limited.		
		VA To Be 2010: All Facilities would like to move forward with the Electronic Medical Records automation. Interoperability among CSBs is desired so they can exchange information among all partners. Standard data definitions will help the Facilities to move towards interoperability.		

Client Management (CL)

CL: Manage Client/Applicant Communication Process				
Item	**Details**			
Description	The ***Manage Client/Applicant Communication*** business process receives individual requests for information, appointments and assistance from prospective and current clients such as inquiries related to eligibility, programs and services, costs, and providers; and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and distributed electronically as appropriate. **NOTE:** The ***Perform Client/Applicant Outreach*** process targets both prospective and current client *populations* for distribution of information about programs, services, and health issues.			
MITA Reference	Source Process Name: *Manage Applicant and Member Communication* Source Process Business Area: *Member Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Service information Provider data; type, location, linguistic and cultural competence	Agency and program policies Client demographics, social, functional, clinical, and financial data		
CL: Manage Client/Applicant Communication: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Description				
This business process is primarily via paper, telephone, & fax; communications are received and sent from various sources using nonstandard formats. The process is inconsistent in the application of the rules and in response timing. Communication is not coordinated among multiple, siloed programs and not systematically triggered by agency wide processes. This Level complies with agency requirements.	The process incorporates direct connectivity to agency programs and provider/ contractors; Web interfaces for inquiries; basic business rules; and state agency specific standards. Confidentiality requirements are automated. Routine communications for client information are standardized and automated within the agency. This Level includes additional data and quality edits.	Communications are primarily electronic, with paper used only as needed. Communications are standardized within the agency and coordination cross agency results in improved efficiencies. Confidentiality requirements are determined via automated business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Communications are handled through HIEs statewide; regular client communications are automatic. All health care agencies collaborate in client communications with providers/ contractors statewide. New client information can also trigger or "push" specific messages to clients regarding special programs and services. However, nonelectronic communications will still be needed. Confidentiality requirements are triggered automatically. This Level adds clinical data.	Client communications posted by an agency can be electronically accessed anywhere in the country. Client communications can be "pushed" when appropriate, but non-electronic communications for the BH population may need to be retained. Nationwide collaborations streamline communications with clients anywhere in the country. This Level adds nationwide technical interoperability.
VA As Is 2010: All Facilities and CSBs are operating at a Level 1. Processes are	**VA As Is 2010:** Some Facilities and some CSBs are operating in a Level 2. Basic			

manual using paper, phone or fax.	components are being met in this level.			
	VA To Be 2010: All Facilities and CSBs would like to move towards a Level 2 maturity level by automating processes.			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is 2010: Most Facilities are at a Level 1. They are using mostly paper.	**VA As Is 2010:** Most CSBs are a Level 2. They utilize Electronic Health Records making information available by automation.			
	VA To Be 2010: The Facilities would like to move to a Level 2 in this area.	**VA To Be 2010:** The CSBs would like to move to a Level 3 and to be completely automated.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is 2010: CSBs at a Level 1 with many operating in a Level 2. All Facilities are using little or no standards.	**VA As Is 2010:** Some CSBs operating at a Level 2. Electronic Health Records are using standards.			
	VA To Be 2010: CSBs would like to move towards completing Level 2 capabilities. All want to move towards Health Information Exchange. The Facilities would like to move towards using national standards.			
Cross Coordination				

Level 1	Level 2	Level 3	Level 4	Level 5
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is 2010: All Facilities are at a Level 1. Little or no coordination is occurring.		**VA As Is 2010:** CSBs are coordinated internally using standards. Data exchanges are not as coordinated and prove to be more problematic for the CSBs.	**VA As Is 2010:** Some CSBs are at Level 4 coordinating with external agencies.	
	VA To Be 2010: The Facilities would like to move towards using standards that are coordinated within their agency.		**VA To Be 2010:** CSBs want to move towards being coordinated with external agencies.	
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
	VA As Is 2010: The Facilities have access to specific client data.	**VA As Is 2010:** CSBs are operating at a Level 3 maturity level. Data extracts are moving towards a Level 4 for some CSBs.		
		VA To Be 2010: The Facilities want to move towards Level 3.	**VA To Be 2010:** CSBs want to move towards Level 4 and external agencies having access to specific client data.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
	VA As Is 2010: CSBs are operating at a Level 2. Using their claims systems to interface with other systems. The			

	Facilities are all operating at a Level 2.			
		VA To Be 2010: CSBs and the Facilities would like interoperability among other systems.		

Client Management (CL)

CL: Manage Client Grievance and Appeal Process				
Item	**Details**			
Description	The ***Mange Client Grievance and Appeal*** business process receives data from the client or the client's agent or representative (Human Rights Councils, advocacy organizations, ACLU, facilities, etc.): records the problem, tracks the problem investigation, appeal and resolution process, and documents communications, dates and outcome; screens for required fields, edits required fields, verifies client information with external entities if available, assigns an ID, tracks the process and timeline, and records the final outcome.			
MITA Reference	Source Process Name: *Manage Member Grievance and Appeal* Source Process Business Area: *Member Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Service data: Services and provider types; program policy; and provider/ contractor information	Provider/contractor data, such as type, location, language, availability. Grievance and Appeal Case Files		
CL: Manage client Grievance and Appeal: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All activities are manual. Client fills out one or more paper forms for various programs and services, which are primarily received via USPS & fax using nonstandard formats. The process is lengthy, and may have inconsistencies between cases of the same type. This Level complies with agency requirements.	The process incorporates Web interfaces for inquiries; scanned files; basic business rules; and state agency specific standards. The process Is partially automated, improving consistency and reducing review time. Correspondence is generated automatically using templates. This Level includes additional data and quality edits.	Client and/or agency staff enter all grievance and appeal information directly into an automated system. BH-MITA standard data and MITA compatible system interfaces are used to initiate and develop the case. The case file is Web-enabled to facilitate sharing among the review team. Cross agency coordination results in a one-stop shop model for both provider/contractor and client appeals. At this Level data is standardized against HL7 RIM.	Client can enter all grievance and appeal information directly at the point of service. The process can be initiated by, tracked, or shared with business partners and clients through HIEs statewide. Clinical data and automated business rules help substantiate case findings and lead to earlier resolution of cases. A client case against a provider/contractor may be triggered directly from the clinical record. This Level adds clinical data.	Interoperability and data sharing agreements across states facilitate case resolution through HIEs nationally. For example, one state can view how other states have resolved similar cases; one state can determine if the client is (or has been) involved in similar cases in other states. This Level adds nationwide technical interoperability.
VA As Is 2010: CSBs at Level 1. Everything is manual.	**VA As Is 2010:** Facilities are using some automation. A system named CHRIS is utilized among the Facilities. DMAS is at Level 2.	**VA As Is 2010:** DMAS has some processes in Level 3.		
	VA To Be 2010: CSBs want more	**VA As Is 2010:** Facilities and DMAS		

	automation.	would like to move towards total automation.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is 2010: CSBs at Level 1. Everything is manual.	**VA As Is 2010:** Facilities are using some automation. A system named CHRIS is utilized among the Facilities. DMAS is at Level 2.			
	VA To Be 2010: CSBs want more automation.	**VA As Is 2010:** Facilities and DMAS would like to move towards automating interfaces.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is 2010: All participants are at a Level 1. Process complies with regulations and all parties use state and federal standards.				
	VA To Be 2010: All parties want internal process to use national standards.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
	VA As Is 2010: DMAS and the Facilities are Level 2 with internal agency processes coordinated.	**VA As Is 2010:** CSBs are at a Level 3 where program processes are coordinated.		
		VA To Be 2010: Move towards internal agency	**VA To Be 2010:** Move towards external	

		processes coordinated.	coordination.	
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is 2010: CSBs have a few automated processes but mostly manual.		**VA As Is 2010:** Facilities use CHRIS and share data with Central Office.	**VA As Is 2010:** DMAS is using Oracle with external agencies.	
	VA To Be 2010: CSBs want to automate processes having access to client specific data.		**VA As Is 2010:** Automate processes for external agency access to data.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is 2010: CSBs have a few automated processes but mostly manual.	**VA As Is 2010:** DMAS is using Oracle with external agencies.	**VA As Is 2010:** Facilities use CHRIS and share data with Central Office.		
	VA To Be 2010: Automate to move towards interoperability between systems.	**VA To Be 2010:** Automate to move towards interoperability between systems.	**VA To Be 2010:** Automate to move towards interoperability between systems and agencies.	

Client Management (CL)

CL: Inquire Client Information Process		
Item	**Details**	
Description	The ***Manage Client Information*** business process is responsible for managing all operational aspects of agency client data, which is the source of comprehensive information about applicants and clients, and their interactions with the state agency. The client database includes demographic, financial, socio-economic, treatment, service, health status, and outcomes information. Business processes that generate applicant or client information send requests to the client database to add, delete, or change this information. The client database provides access to client records to internal and external users.	
MITA Reference	Source Process Name: *Manage Member Information* Source Process Business Area: *Member Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Client demographic, financial, socioeconomic, treatment, service, health status, and outcomes information Referral and placement information	Client communications history Services requested and provided Any interactions related to any client grievance/appeal

CL: Manage Client Information: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. This Level complies with agency requirements.	Inquiries about clients are communicated in a standard format. The process incorporates direct connectivity to agency programs and provider/ contractors; Web interfaces for inquiries; basic business rules; and state agency specific standards. Routine inquiries for client information are standardized and automated within the agency. This Level includes additional data and quality edits.	Inquiries about clients incorporate national data standards, and results are standard, consistent and more accurate. The process has virtual access to client data. Cross agency collaboration results in a one-stop shop, with information accessible to external partners and clients via the Web. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Client databases are federated with HIEs statewide so that any authorized stakeholder can request client specific clinical information. Client health record locator services are integrated into HIEs to enhance responses to inquiries regarding clients. This Level adds clinical data.	Client information is federated with HIEs nationally so that any stakeholder can request provider/contractor information to the extent authorized anywhere in the country. This Level adds nationwide technical interoperability.
VA As Is 2010: Mostly Level 1. The Facilities mostly operate at Level 1 where home office has more automation and	**VA As Is 2010:** Some standards are used and Joint Commission guidelines utilized. Some data exchanges occur			

operates in a Level 2 more often.	but nothing consistently.			
	VA To Be 2010: All Facilities would like to move towards Electronic Medical Records and the automation that goes along with that functionality. Continue to move towards Level 2 and 3 processes.			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is 2010: Mostly Level 1 manual/paper processes occurring.	**VA As Is 2010:** Some internal processes are automated in some Facilities.			
	VA To Be 2010: All Facilities would like to move towards Electronic Medical Records and the automation that goes along with that functionality. Continue to move towards Level 2 and 3 processes.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is 2010: Most Facilities are operating at a Level 1 using some standards such as Joint Commission Standards.	**VA As Is 2010:** Several Facilities are using some national standards (CPT and ICD9 standards) but not all of them.			
	VA To Be 2010: All Facilities would like more automation and to			

	use more standards for their processes.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is 2010: Most Facilities are operating at a Level 1 with some coordination with other programs.	**VA As Is 2010:** Some Facilities are utilizing shared databases for use of patient discharge plans.			
	VA To Be 2010: All Facilities would like to move forward to Level 2 with cross coordination efforts.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is 2010: Most Facilities are operating at a Level 1 with some access to client specific data.	**VA As Is 2010:** Some Facilities are utilizing shared databases.			
	VA To Be 2010: All Facilities would like to move forward to Level 2.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
	VA As Is 2010: Most Facilities are operating at a Level 2 by being able to access databases (with proper security authority) across Facilities.	**VA As Is 2010:** Some Level 3 functionalities exist but still limited.		
		VA To Be 2010: All Facilities would like to move forward		

		with the Electronic Medical Records automation. Interoperability among CSBs is desired so they can exchange information among all partners. Standard data definitions will help the Facilities to move towards interoperability.		

Client Management (CL)

CL: Perform Population & Client Outreach Process		
Item	**Details**	
Description	The ***Perform Population and Client Outreach*** business process originates internally within the Agency to identify and notify prospective and current clients about BH programs and services; create and provide linguistically and culturally appropriate information and educational materials to those same clients; and monitor outreach efforts and effectiveness. Client data is analyzed to develop outreach methods and materials and to target specific populations. **NOTE:** The ***Perform Population and Client Outreach*** process targets both prospective and current client *populations*. The ***Manage Client/Applicant Communication*** process provides assistance and responses to *individuals*.	
MITA Reference	Source Process Name: *Perform Population and Member Outreach* Source Process Business Area: *Member Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Population health data Accountability and quality measure data Service data: Services and provider types; program policy; and provider/ contractor information	Client demographics and service history Client social, functional, clinical, and financial data Provider/contractor data, such as type, location, language, availability.

CL: Perform Population & Client Outreach: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Outreach and education materials are manually prepared and updated. Agencies use TV, radio, and newspaper advertisements to distribute materials and messages. Outreach across multiple, siloed programs is uncoordinated, and linguistic and cultural sensitivity is lacking. Quality and consistency of outreach and education efforts is variable. This Level complies with agency requirements.	Increased use of agency standards for client data improves identification of gaps in client outreach. Agencies add Websites, TV, radio and other media to their outreach methods and can distribute electronic outreach information and messages where viable. Standard outreach information is maintained and available to clients via a Web portal. This Level includes additional data and quality edits	At this level, current and prospective client s can access outreach information available via state Web portals from any service location. Outreach is coordinated with other state agencies using BH-MITA and MITA standard data and interfaces. Automated translation and repositories of cultural and competency appropriate statements facilitates material development. At this Level data is standardized against HL7 RIM.	Client outreach is coordinated regionally, multiagency in scope, and facilitated through HIEs statewide. Clinical and administrative information can automatically trigger outreach and educational material to be sent to the client and/or the provider/ contractor. Outreach materials are automatically generated and sent in response to electronic requests. This Level adds clinical data.	The business process is national in scope, based on analysis of clinical, demographic, and socio-economic indicators and shared among other BH agencies and public programs. Client outreach is facilitated through HIEs nationally. Nationwide collaborations streamline outreach and education to clients anywhere in the country. This Level adds nationwide technical interoperability.
VA As Is 2010: All CSBs are operating in a Level 1. Some CSBs	**VA As Is 2010:** Some CSBs are more automated and use standards			

receive help from the counties for outreach distribution. The Facilities are at a Level 1.	for outreach. Level 1 and Level 2 varies across CSBs.			
	VA To Be 2010: All Facilities and CSBs would like to use standards and move towards a Level 2 maturity.			
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is 2010: Most CSBs are operating at a Level 1. All Facilities are mostly paper.	**VA As Is 2010:** A few CSBs use automation at this level.			
	VA To Be 2010: All Facilities and CSBs would like automation for processes.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
	VA As Is 2010: For the CSBs their communications follow standards and they follow the ADA guidelines. Interfaces with the CSBs and Facilities are using state standards established for Behavioral Health. Standards are used for data exchanges. The Facilities are compliant with the standards.			
		VA To Be 2010: All parties would like to use national standards and move towards Level 3.		

Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is 2010: Some CSBs and all Facilities are at a Level 1 with little coordination between programs or processes.	**VA As Is 2010:** Some CSBs are coordinating processes internally.			
	VA To Be 2010: Move towards obtaining Level 2 coordinating processes internally.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
	VA As Is 2010: CSBs are operating at a Level 2 where internal processes have access to client specific data.			
		VA To Be 2010: CSBs want to move towards Level 3 automation.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is 2010: All participants at a Level 1. CSBs use many Level 2 processes.				
	VA To Be 2010: All participants want interoperability among systems.			

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(CL) Client Management										
Manage Clent/Applicant Communication	**The Manage Client/Applicant Communication business process receives individual requests for information, appointments and assistance from prospective and current clients such as inquiries related to eligibility, programs and services, costs, and providers; and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and distributed electronically as appropriate. NOTE: The Perform Client/Applicant Outreach process targets both prospective and current client populations for distribution of information about programs, services, and health issues.**									
	2010: The CSBs are functioning at a level one for all markers; however, the facilities are more consistently functioning at a level 2 using EHRs and other automation.									
Manage Client Grievance and Appeal	The Mange Client Grievance and Appeal business process receives data from the client or the client's agent or representative (Human Rights Councils, advocacy organizations, ACLU, facilities, etc.): records the problem, tracks the problem investigation, appeal and resolution process, and documents communications, dates and outcome; screens for required fields, edits required fields, verifies client information with external entities if available, assigns an ID, tracks the process and timeline, and records the final outcome.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010: The CSBs are functioning at a level 1; facilities are mostly at level 2 and DMAS is mostly a level 3. The net result for this process is a level 1.									
Manage Client Information	The Manage Client Information business process is responsible for managing all operational aspects of agency client data, which is the source of comprehensive information about applicants and clients, and their interactions with the state agency. The client database includes demographic, financial, socio-economic, treatment, service, health status, and outcomes information. Business processes that generate applicant or client information send requests to the client database to add, delete, or change this information. The client database provides access to client records to internal and external users.									
	2010: Some facilities and CSBs are operating at level 1 or 2; introduction of standards and use of shared databases is occuring at the facilities.									
Inquire Client Information	The Inquire Client Information business process receives requests for client information from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set. The client database includes demographic, financial, socio-economic, treatment, service, health status, and outcomes information.									
	2010: Most facilities are operating at level 1 with some functioning at higher levels using client level data and interoperability.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Perform Population/Client Outreach	The Perform Population and Client Outreach business process originates internally within the Agency to identify and notify prospective and current clients about BH programs and services; create and provide linguistically and culturally appropriate information and educational materials to those same clients; and monitor outreach efforts and effectiveness. Client data is analyzed to develop outreach methods and materials and to target specific populations. NOTE: The Perform Population and Client Outreach process targets both prospective and current client populations. The Manage Client/Applicant Communication process provides assistance and responses to individuals.									
	2010: Most facilities and CSBS are operating at level 1 with some functioning at higher levels using client level data and interoperability.									

Operations Management

Operations Management (OM)

OM: Apply Claim Attachment				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	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/contractor unsolicited, linking it with a trace number to associated claim, validating application level edits, determining if the data set provides all information necessary to adjudicate the claim.			
MITA Reference	Source Process Name: *Apply Claim Attachment* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Transaction Repository Provider/Contractor data		Client data Service/reference file	
OM: Apply Claim Attachment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper; paper claim attachments are sent separately from the claim using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. Not all agencies use claim or attachment equivalents for reimbursement. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Claims are aligned to the HIPAA standards, X12 835 and 837. Attachments are aligned to the HIPAA standard, X12 275. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Attachments are no longer required with direct access to the clinical data stored in HIEs statewide. This Level adds clinical data.	Accessible clinical data available through HIEs nationwide eliminates the need for attachments. This Level adds nationwide technical interoperability.
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**

Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

OM: Apply Mass Adjustment				
Item	**Details**			
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Description	The ***Apply Mass Adjustment*** business process begins with the receipt or notification of retroactive changes involving many claims within a range of dates submitted by multiple provider/contractors. This mass adjustment business process includes identifying the claims that were paid incorrectly during a specified date range, applying parameters to reverse the paid claims and repay correctly. This business process often affects multiple providers/contractors as well as multiple claims. **NOTE:** This should not be confused with the claim adjustment adjudication process.			
MITA Reference	Source Process Name: *Apply Mass Adjustment* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Transaction Repository Provider/Contractor data		Client data	
OM: Apply Claim Attachment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency identifies the claims to be adjusted, sets the parameters, and applies the retroactive rates through primarily manual processes. Not all agencies use mass adjustment equivalents for reimbursement corrections. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Claims are aligned to the HIPAA standards, X12 275 and 837. Identification of claims to be adjusted and application of the adjustment are automated with audit trail. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Mass adjustments are no longer required with direct access to the source data, both clinical and administrative, stored in HIEs statewide. This Level adds clinical data.	Accessible clinical and administrative data available through HIEs nationwide eliminates the need for mass adjustments. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:				
VA To Be:				
Standards				

Level 1	Level 2	Level 3	Level 4	Level 5
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

OM: Authorize Referral				
Item	**Details**			
Description	The ***Authorize Referral*** business process is used when referrals are issued for client services. *Authorize Referral* and *Authorize Service* may follow a similar business process.			
MITA Reference	Source Process Name: *Authorize Referral* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Provider/contractor data Provider/contractor ID Number Client data Treatment plans		Service data Reference data, with diagnosis and procedure code data Correspondence data	
***Question to CMS:** Should the level 2 description really state the HIPAA standard as X12 276/277 instead of X12 277/278.				
OM: Authorize Referral: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Referral data and formats are aligned to conform to the HIPAA standard, X12 277/278. Routine referrals are standardized and automated within the agency. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. Cross agency collaboration results in a one-stop shop, with information accessible to external partners and clients via the Web. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Referral authorization is embedded in provider/contractor/ agency communications, eliminating the need for most referrals. The process queries statewide HIEs for treatment plans and clinical progress data. Built in clinical protocols aid referrals. This Level adds clinical data.	Inter-enterprise business process management between all state health agency systems and real time connectivity eliminates the need for referral authorizations. Accessible clinical data available through HIEs nationwide assists the application of evidence based practices. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **2011 MITA:** Facilities, Reimbursement and CSBs are mostly at a level 1 with some level 2 capabilities.				
VA To Be:	**2011 MITA:**			

	Facilities, Reimbursement and CSBs would like to move to a solid level 2 with more automation.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** Facilities, Reimbursement and CSBs are mostly a level two with some level 3. They are missing HL7 standards.			
VA To Be:		**2011 MITA:** Facilities, Reimbursement and CSBs would like the use of HL7 to advance them to a level 3.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** Facilities, Reimbursement and CSBs are mostly level 2 with some level 3. Their internal processes are coordinated.	**2011 MITA:** A small number of CSBs are operating in a full level 3 with HL7.		
VA To Be:		**2011 MITA:** CSBs and Facilities would like the use of HL7 to move to a level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2011 MITA:** CSBs and Facilities are at level 2.			

VA To Be:		**2011 MITA:** CSBs and Facilities would like the use of HL7 to move to a level 3.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** CSBs and Facilities are at level 2.			
VA To Be:		**2011 MITA:** CSBs and Facilities would like the use of HL7 to move to a level 3.		

Operations Management (OM)

OM: Authorize Service/Level of Service		
Item	**Details**	
Description	The ***Authorize Service/Level of Service*** business process applies to a pre-approved or post-approved service or level of service request. This business process focuses on specific types and numbers of visits, specific services, court ordered treatment, service intensity, and institutional days of stay. Referrals are approved, modified, denied or pended for additional information.	
MITA Reference	Source Process Name: *Authorize Service* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Provider/contractor data Provider/contractor ID Number Client data Treatment plans	Service data Reference data, with diagnosis and procedure code data Correspondence data

Level 1	Level 2	Level 3	Level 4	Level 5
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Service authorization data and formats are aligned to the HIPAA standard, X12 277/278. Routine authorization requests are standardized and automated within the agency. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. Cross agency collaboration results in a one-stop shop, with information accessible to external partners and clients via the Web. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Service authorization is embedded in provider/contractor/ agency communications, eliminating the need for most requests. The process queries statewide HIEs for treatment plans and clinical progress data. Built in clinical protocols aid authorizations. This Level adds clinical data.	Inter-enterprise business process management between all state health agency systems and real time clinical data eliminates the need for service authorizations. Accessible clinical data available through HIEs nationwide assists the application of evidence based practices. This Level adds nationwide technical interoperability.

***Question to CMS:** Should the level 2 description really state the HIPAA standard as X12 276/277 instead of X12 277/278.

Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **2011 MITA:** Facilities, Reimbursement and CSBs are mostly at a level 1 with some				

level 2 capabilities.				
VA To Be:	**2011 MITA:** Facilities, Reimbursement and CSBs would like to move to a solid level 2 with more automation.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** Facilities, Reimbursement and CSBs are mostly a level two with some level 3. They are missing HL7 standards.			
VA To Be:		**2011 MITA:** Facilities, Reimbursement and CSBs would like the use of HL7 to advance them to a level 3.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** Facilities, Reimbursement and CSBs are mostly level 2 with some level 3. Their internal processes are coordinated.	**2011 MITA:** A small number of CSBs are operating in a full level 3 with HL7.		
VA To Be:		**2011 MITA:** CSBs and Facilities would like the use of HL7 to move to a level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2011 MITA:** CSBs			

	and Facilities are at level 2.			
VA To Be:		**2011 MITA:** CSBs and Facilities would like the use of HL7 to move to a level 3.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** CSBs and Facilities are at level 2.			
VA To Be:		**2011 MITA:** CSBs and Facilities would like the use of HL7 to move to a level 3.		

Operations Management (OM)

Calculate Spend-Down Amount				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	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. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels. The ***Calculate Spend-Down Amount*** business process begins with the receipt of client eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the client is assigned to a benefit package or program that requires a predetermined amount the client must be financially responsible for prior to Medicaid payment for any medical services.			
MITA Reference	Source Process Name: *Calculate Spend-Down Amount* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client data		Payment History Data	
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily paper based, manually adding paper bills and receipts until the spend-down amount for each period is met. Not all agencies use claim equivalents for reimbursement. This Level complies with agency requirements.	The process is conducted electronically. Applicants submit electronic reports, and scan, fax, or mail bills and receipts. Providers/ contractors have difficulty tracking spend down and determining whether to bill, as claims are denied when the client has not yet met spent down requirements. This Level includes additional data and quality edits.	The process automatically enters a deductible amount equal to the client's spend-down requirements for the specified period and adjusts it electronically. . Agencies support transmission of spend down information on the X12 270-271. At this Level data is standardized against HL7 RIM.	Providers/ contractors enter new service information into clinical records accessible to any authorized party through HIEs statewide, which can immediately determine spend down. Spend down is essentially eliminated as a distinct business process. This Level adds clinical data.	N/A
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards

VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Collect Client Fees				
Item	**Details**			
Description	The ***Collect Client Fees*** business process begins with receiving client payment per an agency invoice. The process includes documenting the payment, entering the remittance amount, processing the payment, and formatting the results into required output data set for the accounting process.			
MITA Reference	None			
Sample Data	Client data		Client contribution data	
OM: Collect Client Fees: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency receives client fees in the mail using paper invoices and paper checks, using a largely manual process to open and sort mail, enter payments in the system, and record receipt. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. Not all agencies assess client fees. This Level complies with agency requirements.	The process automates more of the process, scanning invoices and checks upon receipt. Grants/cost-based payments are aligned to the HIPAA standards. NOTE: Why is grants/cost based payments aligned with HIPAA standards relevant? This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms, using Web mechanisms when possible to receive electronic payment from the client. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Process is terminated with full alignment with national standards.	NA
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: Central Office is mostly a level 1 with some level 2 components.	Facilities are functioning at a level 2.			
VA To Be	Central Office and Facilities would like to move to a level 2.	Missing the HL7 component and also notes that clients do not send payments		

		electronically.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is	Facilities and Central office are functioning at this level.			
VA To Be		Missing the HL7 component.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Facilities and central office are functioning at this level.			
VA To Be	Cannot achieve level 3 since clients do not make electronic payments.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	Facilities and central office are functioning at this level.			
VA To Be	Cannot achieve level 3 since clients do not make electronic payments.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	Facilities and central office are functioning at this level.			
VA To Be	Cannot achieve			

	level 3 since clients do not make electronic payments.			

Operations Management (OM)

Determine Client Contribution				
Item	**Details**			
Description	The ***Determine Client Contribution*** business process describes the process by which client contribution towards payment is calculated. Fees may be assessed based on the client's ability to pay when certain services are not covered by other funding sources. NOTE: VA CSBs fees are assessed whether the service is covered or not; copays are not an either, or. The ***Determine Client Contribution*** business process begins with the evaluation of a client's financial means to determine ability to pay, usually as compared to the Federal Poverty Level. When a service is rendered, the client's ability to pay is reviewed against the service fee, and the fee is computed as a percentage of the service fee.			
MITA Reference	None			
Sample Data	Client financial data		Agency sliding scale	
OM: Determine Client Contribution: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily paper based, manually adjusting paper bills and receipts. Bills and receipts are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing, and requires manual production of a client invoice. Not all agencies assess client fees. This Level complies with agency requirements.	The process automatically calculates the client contribution and produces the related invoice. Client contribution algorithms are standardized and automated within the agency. This Level includes additional data and quality edits.	BH-specific invoicing processes are phased out as the funding/payment requirements are aligned with national standards. Client invoicing processes are connected to or replaced by other agency systems and processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Providers/ contractors enter new service information into clinical records accessible to any authorized party through HIEs statewide, which can immediately determine client contribution. Access to client financial data also allows for real time adjustments to changing economic situations. This Level adds clinical data.	Client contributions can be automatically determined for any client for any service in any location in the country and immediately transmitted directly to the client through HIEs nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				

VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Develop Sliding Scale				
Item	**Details**			
Description	The ***Develop Sliding Scale*** business process begins with estimating the average client's ability to pay, usually as compared to current Federal Poverty Level data, and assigning a percentage to successive dollar ranges equivalent to client resources. Agencies may also factor in the available budget and estimated client load in setting the scale.			
MITA Reference	None			
Sample Data	Client data Agency budgets		Current Federal Poverty Level data	
OM: Develop Sliding Scale: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Sliding scales are manually developed each year using available federal, state and client data. Data may be incomplete, untimely, and nonstandard, making comparisons difficult. Methods for calculating the scale are simple and may differ from year to year, and may not optimize resources for either the agency or clients. Not all agencies assess client fees. This Level complies with agency requirements.	Methods for developing sliding scales are standardized, and some parts of the process are automated. Formats and data are standardized within the state. This Level includes additional data and quality edits.	BH-specific invoicing processes are phased out as the funding/payment requirements are aligned with national standards. Client invoicing processes are connected to or replaced by other agency systems and processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Sliding scale development is a tool built in to statewide HIE networks, allowing continual and automatic revision of the scale as source data is updated. Multiple sliding scales can be created, if desired, refined for different types of client resources and other factors. This Level adds client level data.	Sliding scales development is automatic and built in to HIE networks nationally. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is	Facilities and CSBs are functioning at this level.			
VA To Be		Working towards level 3 but currently lacks HL7.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is	Facilities and CSBs			

	are functioning at this level. Unsure what standards apply to this process.			
VA To Be		Working towards level 3 but currently lacks HL7.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Facilities and CSBs are functioning at this level.			
VA To Be		Working towards level 3 but currently lacks HL7.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	All entities are functioning at this level with some components of level 3.			
VA To Be		Working towards this level.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	All entities are functioning at this level with some components of level 3.			
VA To Be		Working towards this level.		

Operations Management (OM)

OM: Edit Claims-Encounter				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Edit Claim/Encounter*** business process receives an original or an adjustment claim/encounter data set and determines its submission status, and validates edits, service coverage and coding. The process sends validated data sets to ***Audit Claim/Encounter*** process and data sets that fail audit to the ***Prepare Remittance Advice/Encounter Report*** process.			
MITA Reference	Source Process Name: *Edit Claims-Encounter* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Provider/contractor data Client data: e.g., treatment and progress status data for checking service appropriateness Reference file		Service data: e.g., units and funding limits for services Payment history: ICN, date of service, service, diagnosis codes	
OM: Edit Claims-Encounter: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency receives paper claims and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Paper transactions are batched and scanned (or data entered). Data is not comparable across agency and program silos. Not all agencies use claim equivalents for reimbursement. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Claims are aligned to the HIPAA standards, X12 275 and 837. Translators convert national data standards to statespecific data to support business processes. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Claims edits are minimized with direct access to the clinical and administrative data stored in HIEs statewide. Claim edits are automated using direct access to clinical and administrative data in HIEs. This Level adds clinical data.	Accessible clinical and administrative data available through HIEs nationwide reduces the need for claim edits and allows for complete automation of the edit process. This Level adds nationwide technical interoperability.
VA As Is:				
VA To Be:				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:				
VA To Be:				

Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

Inquire Payment Status		
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**		
Item	**Details**	
Description	The ***Inquire Payment Status*** business process begins with receiving a claim status inquiry via paper, phone, fax or 276 EDI transaction 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.	
MITA Reference	Source Process Name: *Inquire Payment Status* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Claims and encounter adjudication log, edit and audit exceptions, claim attachment, and claim's disposition Claims, encounter reporting, EFT/check preparation and transmitta	Premium and capitation request processing log, exceptions, and payment data

OM: Inquire Payment Status: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces for inquiries; basic business rules; and state agency specific standards. Routine inquiries for provider/contractor information are standardized and automated within the agency. This Level includes additional data and quality edits.	All programs use a centralized web based automated electronic claim status process. BHspecific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards, allowing process sharing with other systems. Interfaces use BHMITA standards that are compatible with Medicaid MITA. Providers/ contractors send HIPAA X12 276 or use online direct data entry and receive HIPAA X12 277 response or find the claim status online. At this Level data is standardized against HL7 RIM.	Payment status is accessible to any authorized party through HIEs statewide. Provider/contractor systems collaborate with the payer system during an episode of care, so the provider/contractor knows the payment status immediately, eliminating the need for payment status inquiry. This Level adds clinical data.	Payment status is available through HIEs nationally. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes	Internal agency	External agency	Non-state entity

	mostly automated	processes/interfaces mostly automated	processes/interfaces mostly automated	processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Manage Drug Rebate				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
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.			
MITA Reference	Source Process Name: *Manage Drug Rebate* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	CMS Unit Rebate Amount (URA) Data Payment History		Drug Code Data Manufacturer Data	
OM: Manage Drug Rebate: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily paper based using nonstandard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing, and impact cost effectiveness. Data access is limited; reports and analyses are costly, untimely and may be inaccurate. Data and process is not comparable across agency and program silos. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with drug manufacturers, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state as agencies centralize rebate processes and drug utilization data from siloed programs to achieve economies of scale, increase coordination, improve rule application consistency, and standardize data to increase rebates. This Level includes additional data and quality edits.	Data is exchanged through automated electronic interchanges (interfaces) between agencies and drug manufacturers. The process has virtual access to clinical records. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Drug rebate is replaced by a new strategy of care and disease management using clinical data in HIEs statewide. Decision support and sophisticated analytic tools allow for care and disease management in real time. This Level adds clinical data.	The new process works through HIEs nationally and necessary information can be accessed to the extent authorized anywhere in the country. This access eliminates redundant collection and interchange of data, and improves real-time processing. This Level adds nationwide technical interoperability.
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces	External agency processes/interfaces	Non-state entity processes/interfaces

		mostly automated	mostly automated	mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Manage Estate Recovery				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	Estate recovery requires States to recover certain Medicaid benefits correctly paid on behalf of an individual, usually when permanently institutionalized. 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, generating notice of intent to file), opening formal estate recovery case, determining value of estate lien, files estate claim of lien, and conduct case follow-up.			
MITA Reference	Source Process Name: *Manage Estate Recovery* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client data		Payment History	
OM: Manage Estate Recovery: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily a mix of paper, phone, fax and proprietary EDI. Non-standardized data and format from multiple sources requires manual compilation of data. Access to data is limited by limited information on and access to complete client data. Generating correspondence is resource intensive and not timely. Lack of data accuracy and completeness and processing time adversely affects the amount of recovery. Data and process is not comparable across agency and program silos. This Level complies with agency requirements.	The process uses electronic and web interchange and automated processes for some activities, like date of death matches, probate petition notices and reports of death. Formats and data are standardized within the state. Inquiries are received and responded to electronically. All programs use HIPAA X12 standards. Formats and data are standardized within the state as agencies centralize estate recovery processes and data from siloed programs to achieve economies of scale. This Level includes additional data and quality edits.	The process has almost eliminated its use of nonelectronic interchange and has automated most processes to the extent feasible. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. Communications to stakeholders and client's personal representatives are consistent, timely, and appropriate. At this Level data is standardized against HL7 RIM.	The data exchange necessary for estate recovery is accessed via regional registries for client and third party resources.	Data exchange is on a national scale. Through peer-topeer collaboration between the agency and provider/contractor 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. This Level adds nationwide technical interoperability.
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces	External agency processes/interfaces	Non-state entity processes/interfaces

		mostly automated	mostly automated	mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Manage Payment Information				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Manage Payment Information*** business process is responsible for managing all the operational aspects of the Payment Information Repository, the source of comprehensive payment information made to and by the state BH agency for health care and support services. These processes send requests to add, delete, or change data in payment records from exchanges with other payment processes.			
MITA Reference	Source Process Name: *Manage Payment Information* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Claims and encounter adjudication log, edit and audit exceptions, claim attachment, and claim's disposition Claims, encounter reporting, EFT/check preparation and transmittal		Premium and capitation request processing log, exceptions, and payment data	
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The business process is focused primarily on meeting reporting requirements for funding. The process uses primarily paper/phone/fax based processing and some proprietary systems, using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Using payment data for analysis or outcome measures requires costly and untimely statistical manipulation. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. Inquiries are received and responded to electronically. All programs use HIPAA X12 standards for claims history records, including COB and encounter data, claims attachments, and premium payments. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. Claims processing is real time. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Profiles of BH enterprise payment history and other BH payment information are accessible to any authorized party through HIEs and regional record locator services statewide. Real time processing makes claims data available almost immediately. Decision support and sophisticated analytic tools allow for ad hoc analysis and reporting in real time. Pointers to selected clinical information link it to payment data to allow ongoing monitoring and quality control. This Level adds clinical data.	Payment information is federated with HIEs nationally so that any stakeholder can access payment information to the extent authorized anywhere in the country. Claims are no longer sent or compiled by the Agency, and direct access eliminates redundant collection and interchange of data, and improves real-time processing. This Level adds nationwide technical interoperability.
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces	External agency processes/interfaces	Non-state entity processes/interfaces

		mostly automated	mostly automated	mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Manage Recoupment				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Manage Recoupment*** business process describes the process of managing provider/contractor recoupment initiated by the discovery of an overpayment. The process then retrieves claims payment data, initiating the recoupment request, or adjudicates the claims adjustment request, notifying the provider/contractor of audit results, finally applying the refund in the system and monitoring payment history until the repayment is satisfied.			
MITA Reference	Source Process Name: *Manage Recoupment* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Payment History		Provider/Contractor data	
OM: Manage Recoupment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily manual using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Data and process is not comparable across agency and program silos. This Level complies with agency requirements.	The process is increasingly automated, incorporating direct connectivity to provider/contractor; Web interfaces for inquiries; basic business rules; and state agency specific standards. Formats and data are aligned with HIPAA and standardized within the state, and increased coordination between the provider/contractor utilization role, recoupments and accounting result in rule application consistency. This Level includes additional data and quality edits.	The process is fully automated and data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, as agencies centralize recoupment processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Claims and payment information is federated with HIEs statewide and can be accessed to the extent authorized. Real time processing makes claims data available almost immediately. This process is virtually eliminated with access to real time clinical and administrative data. This Level adds clinical data.	Claims and payment information is federated with HIEs nationally and can be accessed to the extent authorized anywhere in the country. This process is eliminated with access to real time clinical and administrative data. This Level adds nationwide technical interoperability.
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**

Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Manage Settlement				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Manage Settlement*** business process begins with requesting annual claims summary data from the payment history, reviewing provider/contractor costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider/contractor cost settlement data, calculating the final annual cost settlement, generating and verifying the data, producing provider/contractor notifications, and establishing interim reimbursement rates, sending the cost settlement data set and tracking settlement payments.			
MITA Reference	Source Process Name: *Manage Settlement* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Payment History		Provider/Contractor data	
OM: Manage Settlement: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily manual using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Data and process is not comparable across agency and program silos. This Level complies with agency requirements.	The process is increasingly automated, incorporating direct connectivity to provider/contractor; Web interfaces for inquiries; basic business rules; and state agency specific standards. Formats and data are aligned with HIPAA and standardized within the state. This Level includes additional data and quality edits.	The process has almost eliminated its use of non electronic interchange and has automated most processes to the extent feasible. Data and formats are standardized for automated interchanges. Cross agency collaboration results in a one-stop shop with shared processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Claims and cost information is federated with HIEs statewide and can be accessed to the extent authorized. Real time processing makes claims data available almost immediately. This Level adds clinical data.	Claims and cost information is federated with HIEs nationally and can be accessed to the extent authorized anywhere in the country. This process is eliminated with access to real time clinical and administrative data. This Level adds nationwide technical interoperability.
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**

Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Manage TPL Recovery				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Manage Third Party Liability (TPL) Recovery*** business process receives third party liability data from various sources such as external and internal data matches, referrals, Attorneys, Fraud and Abuse units, providers/contractors and insurers, identifies the provider/contractor or TPL carrier, locates recoverable claims from payment history, creates post-payment recovery files, sends notification to other payers or providers/contractors, receives payment, sends receivable data, and updates payment history.			
MITA Reference	Source Process Name: *Manage TPL Recovery* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client data Insurer data Other Agency Data – DMV, Veterans Administration		Provider/contractor data Indian Health Service INS Fraud case file	
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is a mix of paper, phone, fax and proprietary EDI. Nonstandardized data and format from multiple sources requires manual effort; processes are siloed across programs. The process is accomplished primarily via payerto-provider/ contractor COB. The process is inconsistent in rule application rules, data reporting, and response timing. Data access is limited; reports and analyses are costly, untimely and may be inaccurate. This Level complies with agency requirements.	The process is increasingly automated, incorporating direct connectivity to provider/contractor; Web interfaces for inquiries; basic business rules; and state agency specific standards. Formats and data are aligned with HIPAA and standardized within the state. This Level includes additional data and quality edits.	The process is fully automated, and data and formats are standardized. The process uses BH-MITA standard interfaces for the payer to payer COB process reducing the burden to providers/ contractors and optimizing timeliness. Cross agency collaboration results in a one-stop shop with shared processes. At this Level data is standardized against HL7 RIM.	COB is automatically coordinated through regional HIEs. Client and provider/contractor information is accessible through HIEs statewide and can be accessed to the extent authorized. Response and payment outcomes are immediate. This Level adds clinical data.	Data exchange for COB occurs on a national scale. Client and provider/contractor information is federated with HIEs nationally and can be accessed to the extent authorized anywhere in the country. This process is minimized with access to real time clinical and administrative data. This Level adds nationwide technical interoperability.
VA As Is				
VA To Be				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces	External agency processes/interfaces	Non-state entity processes/interfaces

		mostly automated	mostly automated	mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Operations Management (OM)

Prepare Capitation Premium Payment				
***NOTE:** Business process does not apply to DBHDS (Central Office, CSBs or Facilities)*				
Item	**Details**			
Description	The ***Prepare Capitation Premium Payment*** business process includes premiums for Managed Care Organizations (MCO), Behavioral Health Organizations (BHO), and other capitated programs. This process is scheduled as stipulated by Trading Partner Agreement and includes retrieving intake/enrollment and service transaction data, retrieving the associated rate data, and formatting the payment data into the required outbound transaction data set. **NOTE:** This process does not include sending the capitation payment data set.			
MITA Reference	Source Process Name: *Prepare Capitation Premium Payment* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client data Provider/Contractor data		Payment History	
OM: Prepare Capitation Premium Payment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency identifies clients who have elected or 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. The agency produces paper and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. The agency implements HIPAA X12 820 for electronic premium payments, however, other insurance companies impose their specific Implementation Guide requirements. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	With direct communication accessible through HIEs statewide, payments are made directly to managed care bank accounts. Clinical information is accessed directly from the HIEs if the capitation payment is supplemented for special circumstances, e.g., high risk pregnancy. This Level adds clinical data.	Payment can be distributed to any location in the country through HIEs nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:				

VA To Be:				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

Prepare Client Invoice				
Item	**Details**			
Description	The ***Prepare Client Invoice*** business process begins with a scheduled invoicing timetable. The process includes retrieving client contribution data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing client invoices to recoup client fees.			
MITA Reference	None			
Sample Data	Client data		Client contribution data	
OM: Prepare Client Invoice: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency receives and produces paper invoices and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Paper transactions are batched and scanned (or data entered). Data is not comparable across agency and program silos. Not all agencies assess client fees. This Level complies with agency requirements.	The process automatically calculates the client contribution and produces the related invoice using basic business rules; and state agency specific standards. Grants/cost-based invoices are aligned to the HIPAA standards. NOTE: Why is grants/cost based payments aligned with HIPAA standards relevant? This Level includes additional data and quality edits.	The process uses only standard EDI transactions, using Web mechanisms when possible to send the invoice to the client. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Process is terminated with full alignment with national standards.	NA
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is	Facilities and the CSBs are functioning at this level.			
VA To Be		Need to adopt HL7 messaging standards.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national	Internal agency processes/interfaces	External agency processes/interfaces	Non-state entity processes/interfaces

	standards	mostly use national standards	mostly use national standards	mostly use national standards
VA As Is: CSBs are functioning at this level.	Facilities are functioning at this level.	Facilities would like to move to this level with more automation.		
VA To Be	CSBs would like to move to this level with more automation.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	Facilities and CSBs are functioning at this level with some level 3 components.			
VA To Be		Facilities and CSBs would like to move to this level with the adoption of HL7 messaging standards.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	Facilities and CSBs are functioning at this level; however, the facilities have some level 3 components.			
VA To Be		Facilities and CSBs would like to move to this level; missing HL7.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	Facilities and central office are functioning at this level; however,			

	some CSBs are more interoperable.			
VA To Be		All would like to move to this level.		

Operations Management (OM)

OM: Prepare COB				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Prepare COB*** business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria. This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, and formatting of claims data into the outbound EDI data set.			
MITA Reference	Source Process Name: *Prepare COB* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client data Provider/contractor data		Payment History Trading Partner Data Base	
OM: Prepare COB: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process identifies claims subject to COB prior to payment based on defined criteria. The claim subject to COB is denied and returned; post payment recovery claims use a mix of paper and EDI claims with nonstandard data and formats. Format and content are not HIPAA compliant, and are likely statespecific, using statespecific business rules. Data is not comparable across agency and program silos. Not all agencies use claim equivalents for reimbursement. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Claims are aligned to the HIPAA standards, X12 837. Translators convert national data standards to statespecific data to support business processes. This Level includes additional data and quality edits.	The process is completely automated and uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. All COB is coordinated among data sharing partner agencies in the state. At this Level data is standardized against HL7 RIM.	COB is minimized with direct provider/contractor communications and access to the clinical and administrative data stored in HIEs statewide. The agency can query regional registries for pointers to repositories of client's third party resources. This Level adds clinical data.	Accessible clinical and administrative data available through HIEs nationwide reduces the need for COB, particularly post payment recovery, and allows for complete automation of the COB process. The agency can query registries across the country for pointers to repositories of client's third party resources. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated

VA As Is:				
VA To Be:				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

Prepare Grants/Cost-Based Payment/Invoice				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Prepare Grants/Cost-Based Payment/Invoice*** business process is scheduled as stipulated by Trading Partner Agreement and includes retrieving and converting transaction data. The process includes receiving provider/contractor invoices, retrieving provider/contractor and service data, retrieving the contracted/cost-based rate data associated with the services, formatting the results into required output data set, and producing invoices to be processed through the agency payment system.			
MITA Reference	None			
Sample Data	Client data		Payment History	
OM: Prepare Grants/Cost-Based Payment/Invoice: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency receives and produces paper invoices and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Paper transactions are batched and scanned (or data entered). Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Grants/cost-based payments are aligned to the HIPAA standards, X12 275 and 837. Translators convert national data standards to state-specific data to support business processes. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Process is terminated with full alignment with national standards.	NA
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:				
VA To Be:				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				

VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

Prepare Health Insurance Premium Payment				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Prepare Health Insurance Premium Payment*** business process begins by receiving eligibility information via referrals from providers/contractors, institutions, community services organizations, or phone calls directly from clients; checking for eligibility status with other payers, editing required fields, producing a report, and notifying clients. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. **NOTE:** This process does not include sending the health insurance premium payment data set.			
MITA Reference	Source Process Name: *Prepare Health Insurance Premium Payment* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client data		Payment History	
OM: Prepare Health Insurance Premium Payment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
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. The agency produces paper and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. The agency implements HIPAA X12 820 for electronic premium payments, however, other insurance companies impose their specific Implementation Guide requirements. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. The agency has the flexibility to easily change the criteria for identification of clients eligible for other insurance. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	With direct communication accessible through HIEs statewide, payments are made directly to other insurer bank accounts. Access to clinical information helps to identify members eligible for other insurance programs. This Level adds clinical data.	Payment can be distributed to any location in the country through HIEs nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated

VA As Is:				
VA To Be:				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

Prepare Medicare Premium Payment				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Prepare Medicare Premium Payment*** business process begins with a reciprocal exchange of eligibility information between Medicare and the BH 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 BH client data, generating buy-in files for CMS for verification, and formatting the premium payment data into the required output data set. **NOTE:** This process does not include sending the Medicare premium payments EDI transaction.			
MITA Reference	Source Process Name: *Prepare Medicare Premium Payment* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client data		Medicare Dual Eligible data	
OM: Prepare Medicare Premium Payment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency identifies clients who meet criteria for buy-in to Medicare Part B. The agency exchanges information with the SSA using electronic communication standards specified by SSA. The agency produces paper and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. The agency implements HIPAA X12 820 for electronic premium payments, however, CMS has not adopted the HIPAA standard for premium payment. Agencies use business rules to improve identification of Medicare eligibles, prepare the premium payment calculation, and track the data exchange. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA, which aid identification of candidates for Medicare Buy-in. At this Level data is standardized against HL7 RIM.	With direct communication across state and federal agencies enabled directly or through HIEs statewide, a new payment process is developed. Access to client specific clinical information helps to identify members eligible for Medicare. This Level adds clinical data.	Agency can verify status of buy-in candidate in other states and jurisdictions via HIEs nationwide before generating the premium payment. Payment can be distributed to any location in the country through HIEs. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated

VA As Is:				
VA To Be:				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

OM: Prepare Premium EFT-Check				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Prepare Premium EFT/Check*** business process manages the generation of electronic and paper based reimbursement instruments, including calculation of premium, application of automated or user defined adjustments based on contract, disbursement of premium, association with an X12 820 electronic premium payment transaction when necessary, routing the payment for electronic fund transfer (EFT) or check generation and mailing.			
MITA Reference	Source Process Name: *Prepare Premium EFT/Check* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Premium, stop-loss data, "pay to" instructions, routing instructions, adjustments, incentives		Provider/contractor demographics Accounting rules, rates, funding sources	
OM: Prepare Premium EFT-Check: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency or Department of Finance produces the EFT transaction or a paper check using agency or state DOF standards for format and data content. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Agency encourages electronic billers to adopt EFT payment, and uses the X12 820 standard. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. All electronic billers receive EFT payment. Through inter-agency coordination, multiple agencies share the same EFT process. Interfaces use BH-MITA standards and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Payments are made directly to provider/contractor bank accounts triggered by entries into clinical records accessible through HIEs statewide. This Level adds clinical data.	EFT payments are distributed to any location in the country through HIEs nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:				
VA To Be:				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no	Internal processes	Internal agency	External agency	Non-state entity

national standards	use national standards	processes/interfaces mostly use national standards	processes/interfaces mostly use national standards	processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

OM: Prepare Provider/Contractor EFT-check				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Prepare Provider/Contractor EFT/Check*** business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including: • Calculation of payment amounts for a variety of claims including FFS, pharmacy, and encounters, and the 1099 process • Disbursement of payment from various funding sources • Associating EFT with an X12 835 electronic remittance advice transaction • Routing the payment for EFT or check generation and mailing			
MITA Reference	Source Process Name: *Prepare Provider EFT-Check* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Premium, stop-loss data, "pay to" instructions, routing instructions, adjustments, incentives		Provider/contractor demographics Accounting rules, rates, funding sources	
OM: Prepare Provider/Contractor EFT-check: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency or Department of Finance produces the EFT transaction or a paper check using agency or state DOF standards for format and data content. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Agency encourages electronic billers to adopt EFT payment, and uses the X12 820 standard. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. All electronic billers receive EFT payment. Through inter-agency coordination, multiple agencies share the same EFT process. Interfaces use BH-MITA standards and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Payments are made directly to provider/ contractor bank accounts triggered by entries into clinical records accessible through HIEs statewide. This Level adds clinical data.	EFT payments are distributed to any location in the country through HIEs nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:				
VA To Be:				

Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

Prepare Remittance Advice-Encounter Report				
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Item	**Details**			
Description	The ***Prepare Remittance Advice/Encounter Report*** business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers/contractors 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. **NOTE:** This process does not include sending the remittance advice/encounter EDI Transaction.			
MITA Reference	Source Process Name: *Prepare Remittance Advice/Encounter Report* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Provider/contractor data Client data: e.g., treatment and progress status data for checking service appropriateness		Service data: e.g., units and funding limits for services Reference file	
OM: Prepare Remittance Advice-Encounter Report: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency produces the paper Remittance Advice using state agencyspecific format and data content. Format and content are not HIPAA compliant, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. The agency continues to provide paper RAs to providers/ contractors who are not electronic billers. The agency complies with the HIPAA X12 835 to supply an electronic RA that meets state agency Implementation Guide requirements. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. All electronic billers receive electronic RA. Through interagency coordination, multiple agencies share the same RA process. Interfaces use BH-MITA standards and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	With direct provider/ contractor to payer system communication accessible through HIEs statewide, the RA is replaced by a new accounting mechanism, with RA information directly transmitted.	Payment information can be distributed to any location in the country through HIEs nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:				
VA To Be:				

Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Operations Management (OM)

OM: Price Claim Value Encounter				
***NOTE:** Business process does not apply to DBHDS (Central Office, CSBs or Facilities)*				
Item	**Details**			
Description	The ***Price Claim/Value Encounter*** business process begins with receiving a claim/encounter data set from the ***Audit Claim/Encounter*** process, applies pricing algorithms, calculates premiums, calculates and applies provider/contractor advances, and deducts recoupments. This process is also responsible for ensuring that all adjudication events are documented in the Payment History and are accessible to all Business Areas. **NOTE:** An adjustment to a claim follows generally the same process path.			
MITA Reference	Source Process Name: *Price Claim/Value Encounter* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Provider/contractor data Client data: e.g., treatment and progress status data for checking service appropriateness		Service data: e.g., units and funding limits for services Reference file	
OM: Price Claim Value Encounter: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Selected standard services are automatically priced using rate, fee, and contract reference data. Atypical provider/contractor and other services are manually priced. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. Not all agencies use claim equivalents for reimbursement. This Level complies with agency requirements.	More services are automatically priced and there are fewer pricing exceptions. Most single claim adjustments are automated. Pricing formulas are agency-specific. Claims are aligned to the HIPAA standards, X12 275 and 837. Translators convert national data standards to statespecific data to support business processes. This Level includes additional data and quality edits.	BH agency coordinates with Medicaid and other agencies to utilize a single claim adjudication and pricing process. BHspecific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. Flexible business rules allow maximum flexibility in changing pricing algorithms. At this Level data is standardized against HL7 RIM	Pricing is embedded in communications with direct access to the clinical and administrative data stored in HIEs statewide. As service data is entered into the clinical record, authorization and pricing are immediately established by the payer application. This Level adds clinical data.	The agency uses clinical and administrative data available through HIEs nationwide to automate the process, including comparing and selecting prices based on regional averages or other pricing methodologies. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:				

VA To Be:				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:				
VA To Be:				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:				
VA To Be:				

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(O/M) Operations Management										
Authorize Service/Level of Service	The Authorize Service/Level of Service business process applies to a pre-approved or post-approved service or level of service request. This business process focuses on specific types and numbers of visits, specific services, court ordered treatment, service intensity, and institutional days of stay. Referrals are approved, modified, denied or pended for additional information.									
	2010 To Be: Facilities and Central Office are mostly functioning at level 2; missing the HL7 component for reaching level 3.									
Authorize Referral	The Authorize Referral business process is used when referrals are issued for client services. Authorize Referral and Authorize Service may follow a similar business process.									
	2010: Facilities and CSBs are functioning mostly at a level 2; lacks the HL7 component.									
Apply Mass Adjustment	The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes involving many claims within a range of dates submitted by multiple provider/contractors. This mass adjustment business process includes identifying the claims that were paid incorrectly during a specified date range, applying parameters to reverse the paid claims and repay correctly. This business process often affects multiple providers/contractors as well as multiple claims. NOTE: This should not be confused with the claim adjustment adjudication process.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Apply Claim Attachment	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/contractor unsolicited, linking it with a trace number to associated claim, validating application level edits, determining if the data set provides all information necessary to adjudicate the claim.									
Edit Claims-Encounter	The Edit Claim/Encounter business process receives an original or an adjustment claim/encounter data set and determines its submission status, and validates edits, service coverage and coding. The process sends validated data sets to Audit Claim/Encounter process and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process.									
Price Claim/Value Encounter	The Price Claim/Value Encounter business process begins with receiving a claim/encounter data set from the Audit Claim/Encounter process, applies pricing algorithms, calculates premiums, calculates and applies provider/contractor advances, and deducts recoupments. This process is also responsible for ensuring that all adjudication events are documented in the Payment History and are accessible to all Business Areas. NOTE: An adjustment to a claim follows generally the same process path.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Prepare COB	The Prepare COB business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria. This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, and formatting of claims data into the outbound EDI data set.									
Prepare Premium EFT/Check	The Prepare Premium EFT/Check business process manages the generation of electronic and paper based reimbursement instruments, including calculation of premium, application of automated or user defined adjustments based on contract, disbursement of premium, association with an X12 820 electronic premium payment transaction when necessary, routing the payment for electronic fund transfer (EFT) or check generation and mailing.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Prepare Provider/Contractor EFT/Check	The Prepare Provider/Contractor EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including: • Calculation of payment amounts for a variety of claims including FFS, pharmacy, and encounters, and the 1099 process • Disbursement of payment from various funding sources • Associating EFT with an X12 835 electronic remittance advice transaction • Routing the payment for EFT or check generation and mailing									
Prepare Remittance Advice/Encounter Report	The Prepare Remittance Advice/Encounter Report business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers/contractors 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. NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Prepare Grants/Cost-Based Payment/Invoice	The Prepare Grants/Cost-Based Payment/Invoice business process is scheduled as stipulated by Trading Partner Agreement and includes retrieving and converting transaction data. The process includes receiving provider/contractor invoices, retrieving provider/contractor and service data, retrieving the contracted/cost-based rate data associated with the services, formatting the results into required output data set, and producing invoices to be processed through the agency payment system.									
Prepare Capitation Premium Payment	The Prepare Capitation Premium Payment business process includes premiums for Managed Care Organizations (MCO), Behavioral Health Organizations (BHO), and other capitated programs. This process is scheduled as stipulated by Trading Partner Agreement and includes retrieving intake/enrollment and service transaction data, retrieving the associated rate data, and formatting the payment data into the required outbound transaction data set. NOTE: This process does not include sending the capitation payment data set.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Prepare Health Insurance Premium Payment	The Prepare Health Insurance Premium Payment business process begins by receiving eligibility information via referrals from providers/contractors, institutions, community services organizations, or phone calls directly from clients; checking for eligibility status with other payers, editing required fields, producing a report, and notifying clients. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. NOTE: This process does not include sending the health insurance premium payment data set.									
Prepare Medicare Premium Payment	The Prepare Medicare Premium Payment business process begins with a reciprocal exchange of eligibility information between Medicare and the BH 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 BH client data, generating buy-in files for CMS for verification, and formatting the premium payment data into the required output data set. NOTE: This process does not include sending the Medicare premium payments EDI transaction.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Inquire Payment Status	The Inquire Payment Status business process begins with receiving a claim status inquiry via paper, phone, fax or 276 EDI transaction 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.									
Manage Payment Information	The Manage Payment Information business process is responsible for managing all the operational aspects of the Payment Information Repository, the source of comprehensive payment information made to and by the state BH agency for health care and support services. These processes send requests to add, delete, or change data in payment records from exchanges with other payment processes.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Calculate Spend-Down Amount	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. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels. The Calculate Spend-Down Amount business process begins with the receipt of client eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the client is assigned to a benefit package or program that requires a predetermined amount the client must be financially responsible for prior to Medicaid payment for any medical services.									
Manage Estate Recovery	Estate recovery requires States to recover certain Medicaid benefits correctly paid on behalf of an individual, usually when permanently institutionalized. 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, generating notice of intent to file), opening formal estate recovery case, determining value of estate lien, files estate claim of lien, and conduct case follow-up.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Manage Recoupment	The Manage Recoupment business process describes the process of managing provider/contractor recoupment initiated by the discovery of an overpayment. The process then retrieves claims payment data, initiating the recoupment request, or adjudicates the claims adjustment request, notifying the provider/contractor of audit results, finally applying the refund in the system and monitoring payment history until the repayment is satisfied.									
Manage Settlement	The Manage Settlement business process begins with requesting annual claims summary data from the payment history, reviewing provider/contractor costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider/contractor cost settlement data, calculating the final annual cost settlement, generating and verifying the data, producing provider/contractor notifications, and establishing interim reimbursement rates, sending the cost settlement data set and tracking settlement payments.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Manage TPL Recovery	The Manage Third Party Liability (TPL) Recovery business process receives third party liability data from various sources such as external and internal data matches, referrals, Attorneys, Fraud and Abuse units, providers/contractors and insurers, identifies the provider/contractor or TPL carrier, locates recoverable claims from payment history, creates post-payment recovery files, sends notification to other payers or providers/contractors, receives payment, sends receivable data, and updates payment history.									
Manage Drug Rebate	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.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Collect Client Fees	The Collect Client Fees business process begins with receiving client payment per an agency invoice. The process includes documenting the payment, entering the remittance amount, processing the payment, and formatting the results into required output data set for the accounting process.									
	2010: Facilities and Central Office are functioning mostly at level 3; missing the HL7 component.									
Prepare Client Invoice										
	2010: Facilities and CSBs are functioning at a level 2; lacks the HL7 component.									
Determine Client Contribution	The Determine Client Contribution business process describes the process by which client contribution towards payment is calculated. Fees may be assessed based on the client's ability to pay when certain services are not covered by other funding sources. NOTE: VA CSBs fees are assessed whether the service is covered or not; copays are not an either, or. The Determine Client Contribution business process begins with the evaluation of a client's financial means to determine ability to pay, usually as compared to the Federal Poverty Level. When a service is rendered, the client's ability to pay is reviewed against the service fee, and the fee is computed as a percentage of the service fee.									
	2010: VA CSBs fees are assess whether the service is covered or not; copays are not an either, or.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Develop Sliding Scale	The Develop Sliding Scale business process begins with estimating the average client's ability to pay, usually as compared to current Federal Poverty Level data, and assigning a percentage to successive dollar ranges equivalent to client resources. Agencies may also factor in the available budget and estimated client load in setting the scale.									
	2010: Facilities and CSBs are functioning at a level 2 with some achieving level 3 components.									

Program Management

Program Management (PM)

PM: Develop Agency Goals and Initiatives				
Item	**Details**			
Description	The ***Develop Agency Goals and Initiatives*** business process periodically assesses 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 hurricanes, fires and floods.			
MITA Reference	Source Process Name: *Develop Agency Goals and Initiatives* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Performance measures		Program Information	
PM: Develop Agency Goals and Initiatives: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Agency goals and initiatives are determined in an ad hoc manner on an irregular basis. Agency goals and initiatives are developed by obtaining staff and stakeholder input and building broad based consensus through a labor intensive process of in person meetings and iterative documents. The process is primarily informed by individual opinions and perspectives, not data. This Level complies with agency requirements.	Agency goals and initiatives are determined on a regularly scheduled basis using a systematic and well-defined process. The process uses the Web, video teleconferencing and other technologies to facilitate communications and process speed. The process is informed by a set of agency standardized data on clients and services. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external stakeholders. Communications are standardized across agencies and coordination cross agency results in improved efficiencies for joint planning activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Standardized client specific clinical data is accessible for planning via state HIEs, and data for planning activities is automatically communicated. All health care agencies collaborate in planning communications between agencies and among all agency partners statewide. This Level adds clinical data.	Agency goals and initiatives protocols are integrated into HIEs on a national scale. Data pertinent to the planning process is analyzed and transmitted in real time, shortening development time. Nationwide collaborations streamline planning communications with agency stakeholders nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** Central Office and CSBs are between a level 2 and a level 3.			
VA To Be:		**2011 MITA:** CSBs and Central Office would like to use HL7 messaging standards to move to the next level of		

		maturity.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** CSBs are between a level 2 and a level 3. Central Office is a level 2 and they use NOMS (National Outcome Measures System).			
VA To Be:		**2011 MITA:** CSBs and Central Office would like to be a solid level 3.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: **2011 MITA:** CSBs are mostly a level 2 but many do operate in a level 1. Many disability areas are siloed and a lot of work is still needed.	**2011 MITA:** Central Office is at a level 2.			
VA To Be:			**2011 MITA:** CSBs and Central Office would like to move directly to a level 4 by integrating with consumers.	
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2011 MITA:** CSBs and Central Office are both between a level 2 and a level 3. They are both missing the use of HL7 standards.			
VA To Be:		**2011 MITA:** The		

		use of HL7 messaging standards will move the CSBs and Central Office to a level 3 and above.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** Central Office is a level 2 with electronic access to information and people in an emergency (hurricanes).			
VA To Be:		**2011 MITA:** Central Office would like to move to a level 3 by having information available to plan for emergencies (hurricanes, wounded warriors). Central Office would also like to advance by using HL7 messaging standards.		

Program Management (PM)

Develop and Maintain Program Policy				
Item	**Details**			
Description	The ***Develop and Maintain Program Policy*** business process responds to requests or needs for change in the agency's programs, services, 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 and advocate pressure.			
MITA Reference	Source Process Name: *Develop and Maintain Program Policy* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Operations Management Client Information Provider/Contractor Information		Program Information Service Information Reference Information	
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Policy development occurs in an ad hoc manner on an irregular basis. Policy is developed by obtaining staff and stakeholder input and building broad based consensus through a labor intensive process of in person meetings and iterative documents. The process is primarily informed by individual opinions and perspectives, not data. This Level complies with agency requirements.	Policy development occurs on a regularly scheduled basis using a systematic and well-defined process. The process uses the Web, video teleconferencing and other technologies to facilitate communications and process speed. The process is informed by a set of agency standardized data on clients and services. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external stakeholders. Communications are standardized across agencies and coordination cross agency results in improved coordination for policy activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Standardized client specific clinical data is accessible for policy development via state HIEs, and data for policy activities is automatically communicated. All health care agencies collaborate in policy communications between agencies and among all agency partners statewide. This Level adds clinical data.	Policy development protocols are integrated into HIEs on a national scale. Data pertinent to the policy process is analyzed and transmitted in real time, shortening development time. Nationwide collaborations streamline policy communications with agency stakeholders nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **2011 MITA:** Central Office is between a level 1 and a level 2. They do not use a lot of automation with this business process.				

CSBs are between a level 1 and a level 2. They use the web to inform consumers. Facilities use e-mail and sharepoint for exchanging information and they are between a level 1 and a level 2.				
VA To Be:	**2011 MITA:** CSBs, Central Office and Facilities would like to move into a solid level 2. They would like to increasingly use data for looking at trends to develop policy.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: **2011 MITA:** CSBs, Central Office and Facilities are between a level 1 and a level 2. They use the standards available but part of the problem is there are not a lot of standards in this area. The standards used are: HIPAA and Protected Health standards.				
VA To Be:	**2011 MITA:** CSBs, Central Office and Facilities would like to move into a solid level 2.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** CSBs	**2011 MITA:** Central		

	are mostly a level 2 with some level 3. Missing HL7 standards.	Office is a level 3.		
VA To Be:		**2011 MITA:** Central Office and CSBs would like to be a solid level 3 with the use of HL7 standards.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
***NOTE:** Marker does not apply to CSBs, Facilities and Central Office				
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
***NOTE:** Marker does not apply to CSBs, Facilities and Central Office				
VA As Is:				
VA To Be:				

Program Management (PM)

PM: Formulate Budget				
Item	**Details**			
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.			
MITA Reference	Source Process Name: *Formulate Budget* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	All Enterprise data		Shared analytical data	
PM: Formulate Budget: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Budget formulation occurs in an ad hoc manner but on a scheduled timeframe. Budgets are developed by reviewing past budgets and expenditures, determining desired service mix, and obtaining staff input through a labor intensive process of in person meetings and iterative documents. The process is informed by individual opinions and perspectives and financial data, but not by client and service data. This Level complies with agency requirements.	Budget formulation occurs on a regularly scheduled basis using a systematic and well-defined process. The process uses Web interfaces, basic business rules, and state standardized formats. The web and other technologies facilitate communications and process speed. The process is informed by a set of agency standardized data on clients and services. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external data. Communications are standardized across agencies and coordination cross agency results in improved efficiencies for joint budget activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Standardized client specific clinical data is accessible for planning via state HIEs, and data for budget activities is automatically communicated. All health care agencies collaborate in planning coordinated budgets and services between agencies and among all agency partners statewide. This Level adds clinical data.	Budget formulation protocols are integrated into HIEs on a national scale. Data pertinent to the budget process is analyzed and transmitted in real time, shortening development time. Nationwide collaborations streamline budget communications with agency stakeholders nationwide. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** Central Office has some level 2 characteristics but they are mostly in a level 3. The lack of HL7 messaging standards keeps them at this level.			
VA To Be:		**2011 MITA:** Central		

		Office would like to use HL7 to fully function at level 3.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:		**2011 MITA:** Central Office is at a level 3 by using state standards for formulating budgets. There are no national standards to use with this process.		
***Note:** Maker does not apply for the VA To Be				
VA To Be:				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:		**2011 MITA:** Central Office is at a level 3 by cross coordinating with DPB, DMAS and HHR.		
VA To Be:			**2011 MITA:** Central Office would like to be at a level 4. They would be at this level if they were using HL7 standards. Will work towards implementing HL7.	
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2011 MITA:** Central Office is between a level 2 and a level 3.			
VA To Be:		**2011 MITA:** HL7 standards will move Central Office to level 3.		

Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:		**2011 MITA:** Central Office is mostly at a level 3.		
VA To Be:		**2011 MITA:** HL7 standards will help fully move Central Office to a level 3.		

Program Management (PM)

PM: Generate Financial and Program Analysis Reports				
Item	**Details**			
Description	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, service codes, provider/ contractor types and specialties (taxonomy), retrieving data from multiple internal sources, compiling the data, and formatting into the required data set. **NOTE:** This process does not include maintaining service, reference, or program information.			
MITA Reference	Source Process Name: *Generate Financial & Program Analysis/Report* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client Information Provider/Contractor Information Payment History		Service Information Reference Repository	
PM: Generate Financial and Program Analysis Reports: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is done with a mix of tape, CD and some proprietary internal systems, using nonstandard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and multiple reviews may be conducted by different programs. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with other agencies, programs, and data; basic business rules, and enhanced consistency of responses and timing. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. BH-specific funding requirements are phased out and aligned with national standards, allowing cross program comparison. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized.	This business process interfaces with other review and audit processes through HIEs statewide. This Level adds clinical data.	The process uses process collaboration and has full interoperability with other local, state, and federal programs with national virtual administrative data access and exchange. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** Facilities, Central			

	Office and CSBs are all operating at a level 2.			
VA To Be:			**2011 MITA:** Facilities, Central Office and CSBs would all like to skip level 3 and move directly to a level 4 by automating more and using HL7.	
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** Facilities, Central Office and CSBs are all operating at a level 2.			
VA To Be:		**2011 MITA:** Facilities, Central Office and CSBs would like to move to a level 3 by using more national standards.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** Facilities, Central Office and CSBs are all operating at a level 2.			
VA To Be:		**2011 MITA:** Facilities, Central Office and CSBs would like to move to a level 3 by becoming totally compatible with MITA standards.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data

VA As Is:	**2011 MITA:** Facilities, Central Office and CSBs all have mostly level 2 maturities with some level 3 components.			
VA To Be:		**2011 MITA:** Facilities, Central Office and CSBs would like to move to a level 3 by becoming totally compatible with MITA standards.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** Facilities and Central Office are at a level 2. Some CSBs (approx. ¼) are operating at a level 3.			
VA To Be:		**2011 MITA:** Facilities, Central Office and CSBs would like to be a solid level 3 and ultimately a level 4.		

Program Management (PM)

PM: Identify Block Grant Services				
Item	**Details**			
Description	The ***Identify Block Grant Services*** business process determines the services to be supported through grants. The process examines current state needs, services and trends, estimates service costs, obtains planning council and other stakeholder input, assesses external factors affecting the service plan, assesses agency initiatives and plans, and produces a final service plan.			
MITA Reference	None			
Sample Data	Client Information Outcomes and performance measures Budget and expenditure history		Services history Past block grant applications Block grant history	
PM: Identify Block Grant Services: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identification of block grant services occurs in an ad hoc manner as grants are obtained. Identification of services is accomplished by obtaining staff and stakeholder input and building broad based consensus through a labor intensive process of in person meetings and iterative documents. The process is primarily informed by individual opinions and perspectives, using limited service and outcome data. This Level complies with agency requirements.	Identification of block grant services occurs on a scheduled basis using a systematic and well-defined process. The process uses the Web, video teleconferencing and other technologies to facilitate communications and process speed. The process is informed by a set of agency standardized data on clients, services and outcomes. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external stakeholders. Separate data and process requirements are phased out as the funding/payment and reporting requirements are aligned with national standards. Communications are standardized across agencies and coordination cross agency results in improved coordination for service identification activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Service information is accessible to any authorized party through HIEs statewide for planning purposes. Identification of block grant services is eliminated as a separate process. This Level adds clinical data.	N/A
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** CSBs and Central Office are mostly operating			

	at level 3 with the exception of HL7. Facilities do not use block grants.			
VA To Be:		**2011 MITA:** CSBs and Central Office would like to adopt HL7 standards to fully function within level 3 and above.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** CSBs are at a level 2. They use internal and national standards for their processes.			
VA To Be:		**2011 MITA:** CSBs would like the use of electronic interfaces to move them forward to a level 3 and above.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** CSBs are between a level 2 and a level 3. Cross coordination is internal to the agency.			
VA To Be:		**2011 MITA:** CSBs would like to be a solid level 3. CSBs would like clear categories for reporting.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:		**2011 MITA:** CSBs are mostly operating		

		in a level 3. A few CSBs have some level 4 characteristics. All CSBs have data management systems and some use electronic health records. Central Office is a level 3 with the use of client specific data.		
VA To Be:			**2011 MITA:** CSBs and Central Office would like automation to advance to level 4.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** Some CSBs are operating in a level 2 but most are in a level 3. Central Office is operating at a level 2 because with many processes in a level 3. HL7 messaging is the missing piece.			
VA To Be:		**2011 MITA:** CSBs and Central Office would like to move to a level 3 and they want to achieve that by using HL7 messaging.		

Program Management (PM)

PM: Manage 1099s				
Item	**Details**			
Description	The ***Manage 1099s*** business process describes the process by which 1099 tax forms are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number. The process receives payment and/or recoupment data from the ***Price Claim/Value Encounter*** Process or from the ***Manage Settlements*** process. The 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 as needed. 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.			
MITA Reference	Source Process Name: *Manage 1099s* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	***Price Claim/Value Encounter*** process data		***Manage Settlements*** process data	
PM: Manage 1099s: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using nonstandard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Programs are siloed and multiple 1099s may be created by different payment systems. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with business partners, basic business rules, and enhanced consistency of responses and timing. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Data and formats are standardized nationally. Cross agency collaboration results in shared processes. Interfaces use BH MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized.	This business process interfaces with other processes through HIEs statewide. This Level adds clinical data.	The process has process collaboration and full interoperability with other local, state, and federal programs with national virtual administrative data access and exchange. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:		**2011 MITA:** Central Office is at a level 3. They are primarily automated but lack HL7 standards.		

VA To Be:		**2011 MITA:** Central Office would like to move to a solid level 3 with the use of HL7 standards.		
***Note:** A question to CMS needs to be asked to see what they had in mind when they said, "Interfaces use BHMITA standardized data and are compatible with Medicaid MITA" in the context of managing 1099's?				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:		**2011 MITA:** Central Office is at a level 3. They lack HL7 standards.		
VA To Be:		**2011 MITA:** Central Office would like to move to a solid level 3 with the use of HL7 standards.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:		**2011 MITA:** Central Office is at a level 3. They coordinate with state payables, payroll and patient fund accounting but lack HL7 standards.		
VA To Be:		**2011 MITA:** Central Office would like to move to a solid level 3 with the use of HL7 standards.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:		**2011 MITA:** Central Office is at a level 3. They use client specific data for patient funds but lack HL7 standards.		
VA To Be:		**2011 MITA:** Central Office would like to		

		move to a solid level 3 with the use of HL7 standards.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:		**2011 MITA:** Central Office is at a level 3. They lack HL7 standards.		
VA To Be:		**2011 MITA:** Central Office would like to move to a solid level 3 with the use of HL7 standards.		

Program Management (PM)

PM: Manage Block Grants				
Item	**Details**			
Description	Funding sources for BH services may come from a variety of sources and are often spread across programs. The ***Manage Block Grants*** business process monitors federal funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.			
MITA Reference	None.			
Sample Data	Client Information Provider/contractor Information Accounting Tables		State Financial Management Applications Payment History	
PM: Manage Block Grants: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The business process is focused primarily on meeting reporting requirements as required as conditions for funding. The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using nonstandard formats and data making reporting and analysis difficult. The process is inconsistent in the application of the rules, data reporting, and response timing. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces to cross agency funding data. Formats and data are standardized within the state. All programs use HIPAA X12 standards for claims and other billing and payment transactions. Process automation improves timeliness of compiling funding history. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. BHspecific funding requirements are phased out and aligned with national standards, allowing cross program comparison. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Funding, client, service and outcome information is accessible to any authorized party through HIEs statewide. Real time payment processing makes current funding figures available almost immediately. Block grant management is eliminated as a separate process. This Level adds clinical data.	N/A
***NOTE: 2011 MITA –** In discussing the description of this business process it was noted that the team was unsure if all programs were using HIPAA standard code sets and transactions.				
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** CSBs			

	are mostly a level 2 but this does vary between CSBs. Central Office does not bill block grants.			
VA To Be:	**2011 MITA:** A solid level 2 for all CSBs.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** CSBs and Central Office use national standards. They are between a level 2 and a level 3.			
VA To Be:		**2011 MITA:** A solid level 3 is where CSBs and Central Office would like to be. Ultimately a level 4 by using more standards.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** Central Office and CSBs are mostly in a level 3 with their processes. However neither are using HL7 messaging standards. They ranked themselves at a level 2 because of that.			
VA To Be:		**2011 MITA:** HL7 will move the CSBs and Central Office to the next level.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data

VA As Is:	**2011 MITA:** Central Office is between a level 2 and a level 3.	**2011 MITA:** CSBs are mostly operating in a level 3. Some CSBs are in a level 4.		
VA To Be:			**2011 MITA:** CSBs and Central Office would like to be at a level 4 in the next several years by using HL7 standards.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** Some CSBs are operating in a level 2 but most are in a level 3.			
VA To Be:		**2011 MITA:** A solid level 3 is where the CSBs would like to be in the next several years.		

Program Management (PM)

PM: Manage Federal Funds				
Item	**Details**			
Description	Funding sources for BH services may come from a variety of sources and are often spread across programs. The ***Manage Federal Funds*** business process monitors federal funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.			
MITA Reference	Source Process Name: *Manage State Funds* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client Information Provider/contractor Information Accounting Tables		State Financial Management Applications Payment History	
PM: Manage Federal Funds: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The business process is focused primarily on meeting reporting requirements as required as conditions for funding. The process uses primarily paper/ phone/fax based processing and some proprietary internal systems, using non-standard formats and data making reporting and analysis difficult. The process is inconsistent in rules application, data reporting, and response timing. Most data used is administrative and reporting; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces to cross agency funding data. Formats and data are standardized within the state. All programs use HIPAA X12 standards for claims and other billing and payment transactions. Process automation improves timeliness of compiling funding history. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. BHspecific funding requirements are phased out and aligned with national standards, allowing cross program comparison. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Funding information is accessible to any authorized party through HIEs statewide. Real time payment processing makes current funding figures available almost immediately. Decision support and sophisticated analytic tools allow for ad hoc analysis and reporting in real time. Pointers to selected clinical information link it to funding data to allow ongoing monitoring. Additional information on other funding sources is available for use in this process. This Level adds clinical data.	Funding information is federated with HIEs nationally so that any stakeholder can access funding information to the extent authorized nationwide. Complete virtual clinical record and administrative data access facilitates real time analysis and decisions. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. Most services are instantly authorized or denied from point of service; payment is automatically established without need of invoice. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** Central Office is at a level 2;			

	able to interface with their Federal counter parts electronically.			
VA To Be:		**2011 MITA:** Central Office would like to move to a level 3 by automating several internal programs (in development now – Medicaid Waivers & Part C)		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:		**2011 MITA:** Central Office uses ARRA reporting standards and is at a level 3.		
VA To Be:		**2011 MITA:** Central Office would like to use HL7 messaging standards to be at a full level 3 status.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** Central Office is between a level 2 and a level 3.			
VA To Be:		**2011 MITA:** Central Office would like to be a solid level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
***Note:** Marker does not apply for Central Office				
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems

	claims processing systems			
VA As Is:	**2011 MITA:** Central Office is between a level 2 and a level 3.			
VA To Be:		**2011 MITA:** Central Office would like to be a solid level 3.		

Program Management (PM)

PM: Manage Program Information				
Item	**Details**			
Description	The ***Manage Program Information*** business process is responsible for managing all the operational aspects of the Program Information Repository, the source of comprehensive program information used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information Repository receives requests to add, delete, or change data in program records.			
MITA Reference	Source Process Name: *Manage Program Information* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Program quality measure data Service data store: Services and provider/contractor types covered; program policy; and contract information Client data store: Client demographics, service data; applicant/client financial, social, functional and clinical data		Provider/Contractor data store: Provider/contractor data, such as type, location, availability, gender, linguistic and cultural competence Claims history; encounter history; payment history data stores Care Management population health data	
PM: Manage Program Information: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using nonstandard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. Inquiries are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses clinical data to improve monitoring. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with some shared processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Program information is accessible to any authorized party through HIEs statewide. Pointers to selected clinical information allow ongoing monitoring and quality control. This Level adds clinical data.	Full interoperability with other local, state, and federal programs with complete virtual clinical record and administrative data access. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** Facilities, Central			

	Office and CSB's are at a level 2. CSB's have some offices operating in a level 3.			
VA To Be:		**2011 MITA:** Facilities, Central Office and CSBs would like more automation to move them to a level 3.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** Facilities, Central Office and CSB's are at a level 2.			
VA To Be:		**2011 MITA:** Facilities, Central Office and CSBs would like more standards to move them to a level 3.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** Facilities, Central Office and CSB's are at a level 2.			
VA To Be:			**2011 MITA:** Facilities, Central Office and CSBs would like move directly to a level 4 for cross coordination.	
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2011 MITA:** Facilities, Central Office and CSB's are at a level 2.			

VA To Be:			**2011 MITA:** Facilities, Central Office and CSBs would like move directly to a level 4 with use of client data.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** Facilities, Central Office and CSB's are at a level 2. CSB's have some offices operating in a level 3.			
VA To Be:		**2011 MITA:** Facilities, Central Office and CSBs would to move to a level 3 with the use of HL7.		

Program Management (PM)

PM: Manage State Funds				
Item	**Details**			
Description	Funding sources for BH services may come from a variety of sources and are often spread across programs. The ***Manage State Funds*** business process monitors state and other funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.			
MITA Reference	Source Process Name: *Manage State Funds* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client Information Provider/contractor Information Accounting Tables		State Financial Management Applications Payment History	
PM: Manage State Funds: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The business process is focused primarily on meeting reporting requirements as required as conditions for funding. The process uses primarily paper/ phone/fax based processing and some proprietary internal systems, using non-standard formats and data making reporting and analysis difficult. The process is inconsistent in rules application, data reporting, and response timing. Most data used is administrative and reporting ; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces to cross agency funding data. Formats and data are standardized within the state. All programs use HIPAA X12 standards for claims and other billing and payment transactions. Process automation improves timeliness of compiling funding history. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. BHspecific funding requirements are phased out and aligned with national standards, allowing cross program comparison. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Funding information is accessible to any authorized party through HIEs statewide. Real time payment processing makes current funding figures available almost immediately. Decision support and sophisticated analytic tools allow for ad hoc analysis and reporting in real time. Pointers to selected clinical information link it to funding data to allow ongoing monitoring. Additional information on other funding sources is available for use in this process. This Level adds clinical data.	Funding information is federated with HIEs nationally so that any stakeholder can access funding information to the extent authorized nationwide. Complete virtual clinical record and administrative data access facilitates real time analysis and decisions. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. Most services are instantly authorized or denied from point of service; payment is automatically established without need of invoice. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:		**2011 MITA:** Central Office has a HL7		

		compliant billing system. However, they are not utilizing HL7 at this time. Report at a level 3.		
VA To Be:		**2011 MITA:** Central Office would like to use HL7 and move to a solid level 3.		
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:		**2011 MITA:** Central Office is using controls and state standards when managing state funds. They are at a level 3.		
VA To Be:		**2011 MITA:** Central Office would like to use HL7 and move to a solid level 3.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:		**2011 MITA:** Central Office is at a level 3.		
VA To Be:		**2011 MITA:** Central Office would like to use HL7 and move to a solid level 3.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
***Note:** Marker does not apply to Central Office				
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems

	systems			
VA As Is:		**2011 MITA:** Central Office is at a level 3. They have different internal systems that interface with one another.		
VA To Be:		**2011 MITA:** Central Office would like to use HL7 and move to a solid level 3.		

Program Management (PM)

PM: Monitor Block Grant Requirements				
Item	**Details**			
Description	The ***Monitor Block Grant Requirements*** business process monitors the services provided and outcomes achieved through block grant funding. The process regularly examines the most current provider/contractor data on service delivery and costs, service coverage and improvement, client outcomes, grant expenditures and other factors as required by the grant.			
MITA Reference	None.			
Sample Data	Client Information Outcomes and performance measures Budget and expenditure history		Services information Past block grant data Provider/contractor history	
PM: Monitor Block Grant Requirements: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is done with a mix of tape, CD and some proprietary internal systems, using nonstandard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and multiple reviews may be conducted by different programs. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. The process is informed by a set of agency standardized data on clients, services and outcomes. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external data and stakeholders. Separate data and process requirements are phased out as the funding/payment and reporting requirements are aligned with national standards. Coordination cross agency improves coordination of monitoring activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Client, service, and provider/contractor information is accessible to any authorized party through HIEs statewide for monitoring purposes. Monitoring of block grant services is eliminated as a separate process. This Level adds clinical data.	N/A
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** Central Office and CSBs are between a level 2 and level 3.			
VA To Be:			**2011 MITA:** CSBs	

			and Central Office would like to skip level 3 and move to a level 4 so automation is accessible to any party through the Health Information Exchange. CSBs and Central Office would also like to use HL7 standards.	
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** Central Office and CSBs are a level 2.			
VA To Be:		**2011 MITA:** CSBs and Central Office would like to move to a level 3 but ultimately move to a level 4 over the next several years. They both want to get to the point of using HL7 messaging standards.		
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:		**2011 MITA:** Central Office and CSBs are a level 3.		
VA To Be:			**2011 MITA:** Central Office and CSBs would like to achieve level 4 status over the next several years.	
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2011 MITA:** Central	**2011 MITA:** CSBs		

	Office is a level 2. Central Office accesses client specific data for aggregation purposes. They do not use client specific data for clinical purposes.	are mostly operating at a level 3. Some CSBs are working within a level 4. They use client specific data for clinical purposes.		
VA To Be:			**2011 MITA:** CSBs and Central Office would like to move to level 4 with the use of HL7 messaging standards. Ultimately a level 5 using NHEN.	
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** CSBs and Central Office are in a level 2 status with most processes operating in a level 3. HL7 messaging standards are missing.			
VA To Be:		**2011 MITA:** CSBs and Central Office desire using HL7 messaging standards to move to level 3 and above.		

Program Management (PM)

PM: Perform A-133 Provider Audits				
Item	**Details**			
Description	The ***Perform A-133 Provider Audits*** business process describes the process by which the agency requests and receives audits required by Federal grant recipients. The process involves reviewing audits, and conducting follow up on findings and questionable costs. The OMB A-133 compliance supplement is an extensive guide for auditing Federal grants and their respective recipients.			
***Note to Description:** The Central Office uses a contractor to conduct the A-133 Provider Audits and does follow-up as needed from the audit report. This is assessment is based on the agencies action after receipt of the audit report.				
MITA Reference	None.			
Sample Data	Service data Provider/Contractor data Federal grant data		Payment data Provider/contractor accounting data	
PM: Perform A-133 Provider Audits: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily paper/phone/fax based, using nonstandard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and multiple reviews may be conducted by different programs. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Data and formats are standardized nationally. Cross agency collaboration results in shared review processes. Interfaces use BHMITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized.	This business process interfaces with other review and audit processes through HIEs statewide. This Level adds clinical data.	The process uses process collaboration and has full interoperability with other local, state, and federal programs with national virtual administrative data access and exchange. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is:	**2011 MITA:** Central Office is at a level 2 for this process. This is an in-house, internal process once the formatted (pdf) report is received from an outside entity. The report is received via e-mail.			
VA To Be:	**2011 MITA:** Central			

	Office does not see this process changing in the near future.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** Central Office is at a level 2.			
VA To Be:	**2011 MITA:** Central Office does not see this process changing in the near future.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** Central Office is between a level 1 and a level 2.			
VA To Be:		**2011 MITA:** Central Office would like to move to a solid level 3 by continuing to coordinate internally for this process.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
***Note:** Marker does not apply for Central Office				
VA As Is:				
VA To Be:				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is:	**2011 MITA:** Central Office interfaces with only the people from the audit. They are a level 2.			

	Central Office shares information with the APA for this process when applicable.			
VA To Be:		**2011 MITA:** Central Office would like to advance to a level 3.		

Program Management (PM)

PM: Respond to Consent Decrees				
Item	**Details**			
Description	The ***Respond to Consent Decrees*** process receives and requests consent permissions, stores those permissions, locates the permissions when a specific client's information is requested, ensures that the permissions are followed, and forwards the permissions with the requested data.			
MITA Reference	None.			
Sample Data	Client data		Consent data	
PM: Respond to Consent Decrees: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily paper/phone/fax based using nonstandard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Incorporation of all applicable requirements (HIPAA, 42 CFR pt. 2) may be variable. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. Inquiries are received and responded to electronically. This Level includes additional data and quality edits.	Consent decrees are fully automated and linked to the client's clinical data. The process has virtual access to administrative and clinical records; self adjusting business rules. Data and formats are standardized statewide. Cross agency collaboration results in a one-stop shop, with shared access to consent decrees. Interfaces use BH MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Consent decrees associated with client records are accessible to any authorized party through HIEs statewide. All applicable consent requirements are consolidated and standardized nationally. This Level adds clinical data.	Full interoperability with other local, state, and federal programs with complete virtual clinical record and consent decree access. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time action. This Level adds nationwide technical interoperability.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: **2011 MITA:** Central Office is between a level 1 and a level 2.				
VA To Be:	**2011 MITA:** Central Office would like more automation and standards to move them into a solid level 2.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no	Internal processes	Internal agency	External agency	Non-state entity

national standards	use national standards	processes/interfaces mostly use national standards	processes/interfaces mostly use national standards	processes/interfaces mostly use national standards
VA As Is:	**2011 MITA:** Central Office uses and follows the HIPAA standards. They are at a level 2.			
VA To Be:	**2011 MITA:** Central Office will remain at a level 2. No other standards are currently available to progress to the next level.			
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is:	**2011 MITA:** Central Office works with the CSBs to share information with their processes. They are at a level 2.			
VA To Be:		**2011 MITA:** Central Office would like to move to a level 3 by expanding their processes and coordinate more with others.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is:	**2011 MITA:** Central Office is a level 2 with the use of client specific data.			
VA To Be:		**2011 MITA:** Central Office would like to move to a level 3.		
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems

	claims processing systems			
VA As Is:	**2011 MITA:** Central Office is a level 2 with interoperability.			
VA To Be:		**2011 MITA:** Central Office would like to move to a level 3.		

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(PM) Program Management										
Identify Block Grant Services	**The Identify Block Grant Services business process determines the services to be supported through grants. The process examines current state needs, services and trends, estimates service costs, obtains planning council and other stakeholder input, assesses external factors affecting the service plan, assesses agency initiatives and plans, and produces a final service lan.**									
	2010: Central office and CSB are mostly at a level 2; lacks use of HL7 standards.									
Develop Agency Goals and Initiatives	The Develop Agency Goals and Initiatives business process periodically assesses 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 hurricanes, fires and floods.									
	2010: Central office and CSB are mostly at a level 2; using some national standards but lacks use of HL7 standards.									
Develop and Maintain Program Policy	The Develop and Maintain Program Policy business process responds to requests or needs for change in the agency's programs, services, 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 and advocate pressure.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010: Functioning mostly at a level 1; there do not appear to be any national standards associated with this process; access to client level data and interoperability do not apply to this process.									
Formulate Budget	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.									
	2010: Central office is functioning at a level 2 with some level 3 components; using state standards as HL7 does not apply to this business process.									
Manage Federal Funds	Funding sources for BH services may come from a variety of sources and are often spread across programs. The Manage Federal Funds business process monitors federal funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.									
	2010: Functioning between levels 2 & 3; using ARRA reporting standards; client level data does not apply to this process.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Manage Block Grant	Funding sources for BH services may come from a variety of sources and are often spread across programs. The Manage Block Grants business process monitors federal funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.									
	2010: Central Office and CSBs are functioning at a level 2 with some level components; lacks HL7.									
Monitor Block Grant Requirements	The Monitor Block Grant Requirements business process monitors the services provided and outcomes achieved through block grant funding. The process regularly examines the most current provider/contractor data on service delivery and costs, service coverage and improvement, client outcomes, grant expenditures and other factors as required by the grant.									
	2010: Central Office and CSBs are functioning at a level 2 with some level components; lacks HL7.									
Manage State Fund	Funding sources for BH services may come from a variety of sources and are often spread across programs. The Manage State Funds business process monitors state and other funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.									
	2010: Level 2; Central Office has a HL7 compliant billing system; however, they are not utilizing HL7 at this time.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Manage 1099s	The Manage 1099s business process describes the process by which 1099 tax forms are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number. The process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Manage Settlements process. The 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 as needed. 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.									
	2010: Functioning at a level 3 but lack of HL7 keeps them at level 2									
Perform A-133 Audits	The Perform A-133 Provider Audits business process describes the process by which the agency requests and receives audits required by Federal grant recipients. The process involves reviewing audits, and conducting follow up on findings and questionable costs. The OMB A-133 compliance supplement is an extensive guide for auditing Federal grants and their respective recipients.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010: The Central Office uses a contractor to conduct the A-133 Provider Audits and does follow-up as needed from the audit report. This is assessment is based on the agencies action after receipt of the audit report. Remaining functions are at a level 2.									
Generate Financial & Program Analysis/Report	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, service codes, provider/contractor types and specialties (taxonomy), retrieving data from multiple internal sources, compiling the data, and formatting into the required data set. NOTE: This process does not include maintaining service, reference, or program information.									
	2010: Facilities, CSBs and Central office are all functioning at a level 2.									
Manage Program Information	The Manage Program Information business process is responsible for managing all the operational aspects of the Program Information Repository, the source of comprehensive program information used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information Repository receives requests to add, delete, or change data in program records.									

Behavioral Health

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	2010: Facilities, CSBs and Central office are all functioning at a level 2.									
Respond to Consent Decrees	The Respond to Consent Decrees process receives and requests consent permissions, stores those permissions, locates the permissions when a specific client's information is requested, ensures that the permissions are followed, and forwards the permissions with the requested data.									
	2010: Functioning mostly at a level 1									

Provider Contractor Management

Provider/Contractor Management (P/CM)

P/CM: Award Administrative Contract				
Item	**Details**			
Description	The ***Award Administrative Contract*** business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses. 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.			
MITA Reference	Source Process Name: *Award Administrative Contract* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	1. Previous RFPs 2. Operational data stores 3. Strategic IT Plan 4. Enterprise Architecture			
P/CM: Award Administrative Contract: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
At this level, the Award Administrative Contract business process uses indeterminate format for application data. Much of the information is manually validated. Staff contact external and internal document verification sources via phone, fax. Decisions may be inconsistent. Requires large numbers of staff. Decisions may take several days.	At this level, the Award Administrative Contract business process uses application data that is standardized within the state. Contractors can submit applications via a portal. Verifications are a mix of manual and automated steps. Consistency is improved. Requires fewer staff. Process takes less time than Level 1.	At this level, the Award Administrative Contract uses application data that is standardized nationally. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate. Services for the following steps and can be shared. 1. Verify Credentials 2. Verify ID 3. Assign ID 4. Assign Rates 5. Negotiate Contract	At this level, the Award Administrative Contract business process interfaces with other processes via federated architectures.	At this level, the Award 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.

Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: CSBs are at level 1. Billing and IT contracts exist but they vary by county.	BHDS is between levels 2 & 3. There are no contracts for administrative services with the CSBs.			
VA To Be: The CSBs want to work toward greater consistency and level 2.	BHDS wants to work toward becoming a full level 3.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: The CSBs and BHDS are at level 1.				
VA To Be: There are no national standards known so it is unlikely that there will be progression.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	The CSBs and BHDS are at level 2.			
VA To Be	The goal will be to work toward level 3 with greater cross coordination.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is: N/A				
VA To Be: N/A				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited	Interoperability with	Interoperability with	Interoperability with

	interoperability internally or limited to claims processing systems	internal agency systems other than claims processing	external agency systems other than claims processing	non-state entity systems
VA As Is: N/A				
VA To Be: N/A				

Provider/Contractor Management (P/CM)

P/CM: Award Health Services Contract				
Item	**Details**			
Description	The ***Award Health Services Contract*** business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.			
MITA Reference	Source Process Name: *Award Health Services Contract* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Contractor Master Registry Other per Type of Contractor			
P/CM: Award Health Services Contract: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Indeterminate format for proposal data. Much of the information is manually validated. Staff contact external and internal document verification sources via phone, fax. Decisions may be inconsistent. Requires large numbers of staff. Decisions may take several days.	Application data are standardized within the state. Contractors can submit applications via a portal. Verifications are a mix of manual and automated steps. Consistency is improved. Requires fewer staff. Process takes less time than Level 1.	Application data are standardized nationally. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate. Services will created for the following steps and can be shared. 1. Verify Credentials 2. Verify ID 3. Assign ID 4. Assign Rates 5. Negotiate Contract.	Level 3 capabilities augmented by some new capabilities. External and internal validation sources automatically send notice of change in contractor status. Recertification notices are automatically generated. Clinical data, if useful in processing the enrollment request is accessible by direct access. Manual steps only required for exception handling.	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. Any data exchange partner can send a notification regarding a contractor enrolled with the state Medicaid program.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: The CSBs are between a 1 & 2. There is some consistency within	BHDS is at Level 2.			

counties but not across all 40 CSBs.				
VA To Be: The goal for the CSBs is to work toward more consistency and level 2.	Virginia requires paper submission of proposals & contracts. Unless this requirement is repealed, full automation will not occur. BHDS does electronically release its RFPs.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: The CSBs and BHDS are at level 1.				
VA To Be: There are no national standards known so it is unlikely that there will be progression.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	The CSBs and BHDS are at level 2.			
VA To Be	The goal will be to work toward level 3 with greater cross coordination.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is: The CSBs and BHDS are at level 1. Any data that is shared is de-identified.				
VA To Be: We don't see change in this practice as likely.				
Interoperability				

Level 1	Level 2	Level 3	Level 4	Level 5
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is: N/A				
VA To Be: N/A				

Provider/Contractor Management (P/CM)

P/CM: Close-out Administrative Contract				
Item	**Details**			
Description	The ***Close-out Administrative Contract*** business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.			
MITA Reference	Source Process Name: *Close-out Administrative Contract* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Contractor Database			
P/CM: Close-out Administrative Contract: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
At this level the Close-Out Administrative Contract business process uses indeterminate connectivity to client. Internal and external inputs and outputs are received or sent manually via paper, telephone and fax. Decisions may be inconsistent. Requires large numbers of staff. Inconsistent timing for response to primary client.	At this level, the Close-Out Administrative Contract business process is beginning to use electronic interchange and standardized application data within the state. Contractors can submit applications via a portal. Verifications are a mix of manual and automated steps. Consistency is improved. Requires fewer staff. Process takes less time than Level 1.	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. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate.	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.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: The CSBs are at level 1. BHDS is between levels 1 & 2.				
VA To Be: The goal				

will be to work toward level 2 with greater automation.				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: The CSBs and BHDS are at level 1.				
VA To Be: There are no national standards known so it is unlikely that there will be progression.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is: N/A				
VA To Be: N/A				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is: N/A				
VA To Be: N/A				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is: N/A				
VA To Be: N/A				

Provider/Contractor Management (P/CM)

P/CM: Close-out Health Care Services Contract				
Item	**Details**			
Description	The Close-out Health Care Services Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.			
MITA Reference	Source Process Name: *Close-out Health Care Services Contract* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Contractor Registry			
P/CM: Close-out Health Care Services Contract: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
At this level, the *Close out Health Services Contract* business process has: ■ Indeterminate connectivity to client ■ Inconsistent timing for response to primary client ■ Multiple data formats and semantics ■ External inputs & outputs are received/sent manually via paper, telephone, & fax Transactions are individually reviewed using inconsistent interpretation of guidelines responded to via paper/USPD or fax	At this level, the *Close out Health Services Contract* business process: ■ Improves on Level 1 capability plus by: ■ Point-to-point or wrapped connectivity to client ■ Point-to-point interfaces (trading partner agreements) segregated by interface type ■ Enhanced consistent timing for response to primary client ■ Different interfaces with different data format and semantics ■ Transactions are received and responded to via EDI,	At this level, the *Close out Health Services Contract* business process: ■ Improves on Level 3 capability plus: ■ Virtual access to administrative and clinical records ■ Increased use of clinical data ■ Focused data – data of record ■ Use of metadata ■ Self adjusting business rules ■ Use of clinical data to increase the accuracy of processes ■ Clinical staff focuses on exception cases Members empowered to make own treatment decisions	At this level, the *Close out Health Services Contract* business process: ■ Incorporates Level 3 capability plus ■ Virtual records ■ Use of clinical data ■ Focused data – data of record ■ Use of metadata ■ Self adjusting business rules ■ Use of clinical data to increase the accuracy of processes ■ Clinical staff focuses on exception cases. Members empowered to make own treatment decisions	At this level, the *Close out Health Services Contract* business process: ■ Improves on Level 4 capability plus: ■ Point-to-point collaboration ■ Content sensitive business logic ■ Business Process Management ■ Metadata – Shared nationally ■ Full interoperability with other local, state, and federal programs to provide complete virtual patient clinical record and administrative data ■ Access to

	Web Portal Use of electronic Claim Attachment for Adjudication			national clinical guidelines Most services instantly authorized or denied from point of service; payment automatically established without need of invoice
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: The CSBs and BHDS are at Level 1. This tends to be an ad hoc process for the CSBs. It was noted that this would not apply for the CSBs at Central Office.				
VA To Be: The goal will be to work toward level 2 with greater automation.				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: The CSBs and BHDS are at Level 1.				
VA To Be: There are no national standards known so it is unlikely that there will be progression.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is		The CSBs are		

		between a 2 & 3. Central Office is at a 3.		
VA To Be		The goal will be to work toward level 3 & 4 with greater cross coordination.		
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	The CSBs and BHDS are at level 2.			
VA To Be	The goal will be to work toward level 3.			
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	The CSBs and BHDS are at level 2.			
VA To Be	The goal will be to work toward level 3.			

Provider/Contractor Management (P/CM)

P/CM: Inquire Contractor Information				
Item	**Details**			
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
Description	The ***Inquire Contractor Information*** business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the ***Send Outbound Transaction*** process.			
MITA Reference	Source Process Name: *Inquire Contractor Information* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Contractor Registry			
P/CM: Inquire Contractor Information: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Inquiries are received from different sources to obtain information about a contractor in non-standard formats. Most requests are sent via telephone, fax, or USPS. Research is performed manually. Responses are inconsistent and manual. There may be delays in responses. Complies with agency goals and expectations.	Routine inquiries for contractors are standardized and automated within the agency. Responses are immediate or within batch response parameters. Responses are consistent and timely. A reduced workforce is required to handle problems and direct telephone inquiries.	MITA standard interfaces are used for inquires regarding contractor information. Other agencies statewide can adopt MITA standard interfaces and participate in the inquiry process.	Contractors are registered statewide so that any stakeholder can request contractor information to the extent authorized.	Contractor registry is national so that any stakeholder can request contractor information to the extent authorized anywhere in the country.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national	Internal agency processes/interfaces	External agency processes/interfaces	Non-state entity processes/interfaces

	standards	mostly use national standards	mostly use national standards	mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Provider/Contractor Management (P/CM)

P/CM: Manage Contractor Communication				
***NOTE:** Business process does not apply to DBHDS (Central Office, CSBs or Facilities)*				
Item	**Details**			
Description	The ***Manage Contractor Communication*** business process receives requests for information, appointments and assistance from contractor such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed and produced for distribution via the Send Outbound Transaction process. **NOTE:** Inquiries from prospective and current contractors are handled by the ***Manage Contractor Communication*** process by providing assistance and responses to individual entities, i.e., bi-directional communication. The ***Perform Contractor Outreach*** process targets both prospective and current contractor populations for distribution of information regarding programs, policies and other issues.			
MITA Reference	Source Process Name: *Manage Contractor Communication* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Contractor Registry Benefit Repository			
P/CM: Manage Contractor Communication: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
At this level, the Manage Contractor Communication process is primarily conducted via paper and phone. Contractor communications are likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target contractors,	At this level, the Manage Contractor Communication process contractor communications are primarily conducted via paper and phone. However, states begin using Websites to provide contractor information, and accept inquiries that can be responded to online or by phone. Contractor communications processes begin to be centralized to	At this level, the Manage Contractor Communication process contractor communications are primarily electronic, with paper used only secondarily. Communications are centralized ensuring agency-wide coordination and greater ability to measure the efficacy of provider communications. Contractor registries use standardized	At this level, the Manage Contractor Communication Process Level 4 may include support for contractor communications via PHRs for prospective and current members. Clinical data may be incorporated into communications to improve quality of information and include medical outcomes and results.	At this level, the Manage Contractor Communication process Level 5 may support collaborative discernment of communication needs of prospective and current contractors via PHRs. Interoperability and data sharing agreements among states will facilitate contractor communications across state lines.

may encounter obstacles to delivery, e.g., incorrect or lack of contact information. Responses may be untimely, inconsistent and is labor intensive.	achieve economies of scale. Despite some progress many responses continue to be untimely and labor intensive.	contact data, including NPS address standards, to alleviate postal delivery failures.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Provider/Contractor Management (P/CM)

P/CM: Manage Contractor Information				
Item	**Details**			
***NOTE:* Business process does not apply to DBHDS (Central Office, CSBs or Facilities)**				
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.			
MITA Reference	Source Process Name: *Manage Contractor Information* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Receive request to update contractor data repository			
P/CM: Manage Contractor Information: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Requests are received from disparate sources in indeterminate formats. Validation is inconsistent and not rules-based. There are delays in completing updates. Duplicate entries may go undetected. Irregular notification of change to users and processes that need to know.	Requests are standardized and automated. Validation is consistent. Updates are timelier. More automation of rules to maintain integrity of data repository. Change is immediately available to users and processes that need to know.	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.	Level 4 is (TBD)	Level 5 is (TBD)
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				

Level 1	Level 2	Level 3	Level 4	Level 5
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Provider/Contractor Management (P/CM)

P/CM: Manage Health Services Contract				
Item	**Details**			
Description	The ***Manage Health Services Contract*** business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses. 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.			
MITA Reference	Source Process Name: *Manage Health Services Contract* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Previous RFPs Operational data stores Strategic IT Plan Enterprise Architecture			
P/CM: Manage Health Services Contract: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
At this level, the *Manage Health Services Contract* business process is likely primarily paper/phone/fax based processing and some proprietary EDI. Timeliness of responses to inquiries and data reporting is indeterminate.	At this level, the *Manage Health Services Contract* business process is increasing its use of electronic interchange. Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data. Centralization increases consistency of communications.	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. Data is standardized for automated electronic interchanges. Communications are consistent, timely and appropriate.	At this level, the *Manage Health Services Contract* business process interfaces with other processes via federated architectures.	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, multiaxial processing.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is	The CSBs are			

	between a 1 & 2. BHDS is at level 2. At least some of the CSBs make electronic payments to venders.			
VA To Be	The goal will be to work toward levels 2 & 3 with greater automation.			
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: The CSBs and BHDS are at level 1.				
VA To Be: There are no national standards known so it is unlikely that there will be progression.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	The CSBs and BHDS are at level 2.			
VA To Be	The goal will be to work toward level 3 with greater cross coordination.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is	The CSBs and BHDS are at level 2. There is external agency access to client specific data, but it does not meet all of the criteria of levels 3 & 4.			
VA To Be	The goal will be to work toward level 3.			
Interoperability				

Level 1	Level 2	Level 3	Level 4	Level 5
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is	The CSBs and CSBs at Central Office are between a 1 & 2.			
VA To Be	The goal will be to work toward fully meeting level 2.			

Provider/Contractor Management (P/CM)

P/CM: Monitor Administrative Contract				
Item	**Details**			
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.			
MITA Reference	Source Process Name: *Monitor Administrative Contract* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Contractor Database			
P/CM: Monitor Administrative Contract: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
At this level, the Manage Administrative Services Contract business process uses indeterminate format for application data. Much of the information is manually validated. Staff contact external and internal document verification sources via phone, fax. Decisions may be inconsistent. Requires large numbers of staff. Decisions may take several days.	At this level, the Manage Administrative Services Contract business process uses application data that is standardized within the state. Contractors can submit applications via a portal. Verifications are a mix of manual and automated steps. Consistency is improved. Requires fewer staff. Process takes less time than Level 1.	At this level, the Manage Administrative Services Contract uses application data that is standardized nationally. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate. Services created for the following steps and can be shared. 1. Verify Credentials 2. Verify ID 3. Assign ID 4. Assign Rates 5. Negotiate Contract	At this level, the Manage Administrative Services Contract business process interfaces with other processes via federated architectures.	At this level, the Manage 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.

Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is: The CSBs and BHDS are at level 1.				
VA To Be: The goal will be to work toward level 2 with greater automation.				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is: The CSBs and BHDS are at level 1.				
VA To Be: There are no national standards known so it is unlikely that there will be progression.				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is	The CSBs and BHDS are at level 2.			
VA To Be	The goal will be to work toward level 3 with greater cross coordination.			
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is: The CSBs and BHDS are at level 1.				
VA To Be: The goal will be to work toward level 2.				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited	Interoperability with	Interoperability with	Interoperability with

	interoperability internally or limited to claims processing systems	internal agency systems other than claims processing	external agency systems other than claims processing	non-state entity systems
VA As Is	The CSBs and BHDS are at level 2.			
VA To Be	The goal will be to work toward level 3.			

Provider/Contractor Management (P/CM)

P/CM: Perform Potential Contractor Outreach				
***NOTE:** Business process does not apply to DBHDS (Central Office, CSBs or Facilities)*				
Item	**Details**			
Description	The ***Perform Potential Contractor Outreach*** business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures. For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs. For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives. Contractor outreach communications are distributed through various mediums via the ***Send Outbound 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.			
MITA Reference	Source Process Name: *Perform Potential Contractor Outreach* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Care Management population health data Program Quality Management quality measure data Benefit Repository Member Registry Contractor Registry Provider Registry			
P/CM: Perform Potential Contractor Outreach: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
At this level, the *Perform Potential Contractor Outreach* process is primarily conducted via paper and phone. Outreach is likely uncoordinated among multiple, "siloed" programs and not systematically triggered by	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. Outreach may be more coordinated because programs	At this level, the *Perform Potential Contractor Outreach* process is primarily electronic, with paper used only secondarily. Outreach is centralized which ensures that regardless of outreach campaign, current and prospective providers will be able to access	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,	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

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.	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. Program quality improvement initiatives are 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.	information. This ensures agency-wide outreach coordination and greater ability to measure the efficacy of outreach. Use of electronic communications makes outreach material more feasible and cost-effective. 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 socioeconomic indicators, which provide basis for policy directives, support targeting contractors for outreach. Contractor registries use standardized contact data, including NPS address standards, to alleviate postal delivery failures.	and their resulting policy directives.	monitoring at the agency, in the RHIO, EHRs, and the individuals' PHR.
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				

VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

Provider/Contractor Management (P/CM)

P/CM: Support Contractor Grievance and Appeal	
***NOTE:** Business process does not apply to DBHDS (Central Office, CSBs or Facilities)*	
Item	**Details**
Description	The ***Support Contractor Grievance and Appeal*** business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the ***Manage Contractor Communications*** process via the ***Receive Inbound Transaction*** process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are distributed to the contractor information file. The contractor is formally notified of the decision via the ***Send Outbound Transaction*** process. This process supports the ***Program Quality Management*** business area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. **NOTE:** States may define "grievance" and "appeal" differently, perhaps because of state laws. *This process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal for example when an application is denied.
MITA Reference	Source Process Name: *Support Contractor Grievance and Appeal* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp
Sample Data	Benefit Repository: Services and provider types covered; program policy; and health plan contractor information Contractor Registry: Contracted service areas, MCO provider network and other provider data Provider Registry: Provider data, such as type, location, availability. Grievance and Appeal Case File Repository

P/CM: Support Contractor Grievance and Appeal: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
At this level, the *Support Contractor Grievance & Appeal* process is entirely paper based, which results in poor document management and process	At this level, the *Support Contractor Grievance & Appeal* process conducts much of its business electronically, except where paper documents are required by	At this level, the *Support Contractor Grievance & Appeal* process continues to conduct most of its business electronically, except where paper documents	At this level, the *Support Contractor Grievance & Appeal* process is able to interface with RHIOs to access standardized clinical data needed for review	At this level, the *Support Contractor Grievance & Appeal* process enables contractors to file grievances and appeals in a collaborative environment via

inefficiencies that impact timeliness. Grievances and appeals are filed, managed, and resolved by siloed programs, leading to inconsistent application or relevant laws and administrative policies and inhibiting performance monitoring. Providers may have difficulty: Finding the "Right Door" for filing grievances and appeals Accessing program rules to discern the merit of their grievance or appeal Getting assistance on their case or providing additional information Receiving consistent responses or communications that are linguistically, culturally and competency Appropriate.	law, which are OCR'd for electronic data capture. Agencies begin to centralize or standardize the administration of this process to achieve economies of scale, thereby increasing coordination and improving consistency by which rules are applied. and appeals disposed. Communications are more consistent. Contractors have limited access to program rules to discern whether their grievances or appeals have merit. Initial review and information gathering must be conducted by phone or in person. These changes improve process timeliness, document management, and supports business activity monitoring of performance measures, which in turn may provide data needed for process improvements.	are required by law, which are OCR'd for electronic data capture. 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. However, clinical data is still paper-based and difficult to access in a timely manner. The process is administered as part of the Medicaid enterprise. As a result: 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. Communications are consistent and timely. The process supports	and disposition of grievances and appeals with utmost timeliness. Analysis of business rules to which the agency must adhere is automated, improving review turn around and consistency. 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. Providers can access program rules to discern whether their grievances or appeals have merit. Initial review and information gathering can be conducted electronically via PHRs.	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. This optimizes resources, timeliness, and disposition consistency.

		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.		
Automation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
All/mostly paper	Internal processes mostly automated	Internal agency processes/interfaces mostly automated	External agency processes/interfaces mostly automated	Non-state entity processes/interfaces mostly automated
VA As Is				
VA To Be				
Standards				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Use few or no national standards	Internal processes use national standards	Internal agency processes/interfaces mostly use national standards	External agency processes/interfaces mostly use national standards	Non-state entity processes/interfaces mostly use national standards
VA As Is				
VA To Be				
Cross Coordination				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Little/no coordination across processes or with other programs	Internal agency operational processes coordinated	Internal agency program processes coordinated	External agency program and operational processes coordinated	Non-state entity program and operational processes coordinated
VA As Is				
VA To Be				
Client Data				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**

Little/no access to client specific data	Internal processes have access to client specific data	Internal agency processes have access to client specific data	External agency processes have access to client specific data	Non-state entity processes have access to client specific data
VA As Is				
VA To Be				
Interoperability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
None	Limited interoperability internally or limited to claims processing systems	Interoperability with internal agency systems other than claims processing	Interoperability with external agency systems other than claims processing	Interoperability with non-state entity systems
VA As Is				
VA To Be				

MITA SS-A Summary

5/24/2011

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
(P/CM) Provider/Contractor Management										
Monitor Administrative Contract	**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.**									
	2010: Functioning mostly at a level 1; no identifiable standards to aspire to; functioning at a level 2 for Cross Coordination and Interoperability.	1	2							
Award Health Services Contract	The Award Health Services Contract business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.									
	2010: Functioning across levels 1 and 2; no identifiable standards to aspire to.	1	2							
Close-Out Health Care Services Contract	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.									
	2010: Functioning across levels 1, 2 and, 3; no identifiable standards to aspire to; functioning at a level 3 for Cross Coordination, Access to Client Level Data and Interoperability.	1	2							

GOVERNOR'S CONFIDENTIAL WORKING PAPERS

MITA SS-A Summary

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Manage Health Services Contract	The Manage Health Services Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses. 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.									
	2010: Functioning at a level 2; no identifiable standards to aspire to.	2	3							
Close-Out Administrative Contract	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.									
	2010: Functioning at a level 1; no identifiable standards to aspire to.	1	2							
Award Administrative Contract	The Award Administrative Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses. 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.									
	2010: Functioning across levels 1 and 2; no national standards to aspire to.	1	2							

GOVERNOR'S CONFIDENTIAL WORKING PAPERS

MITA SS-A Summary

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
Manage Contractor Information	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.									
	This business process does not apply to any DBHDS entity.	n/a	n/a							
Support Contractor Grievance and Appeal	The Support Contractor Grievance and Appeal business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Contractor Communications process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are distributed to the contractor information file. The contractor is formally notified of the decision via the Send Outbound Transaction process. This process supports the Program Quality Management business area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. NOTE: States may define “grievance” and “appeal” differently, perhaps because of state laws. *This process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor									

GOVERNOR’S CONFIDENTIAL WORKING PAPERS

MITA SS-A Summary

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	This business process does not apply to any DBHDS entity.	n/a	n/a							
Inquire Contractor Information	The Inquire Contractor Information business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.									
	This business process does not apply to any DBHDS entity.	n/a	n/a							
Perform Potential Contractor Outreach	The Perform Potential Contractor Outreach business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures. For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs. For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives. Contractor outreach communications are distributed through various mediums via the Send Outbound 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.									

GOVERNOR'S CONFIDENTIAL WORKING PAPERS

MITA SS-A Summary

Business Area/Process	BPM Description BCM Comment - "To Be"	BCM "As Is" Level	BCM "To Be" Level	MMIS			Non - MMIS		Other	Revisit Next SS-A
				RFP Scope	Pre-Imp ISR / EWO	Post-Imp ISR / EWO	Business Process Only	DMAS System		
	This business process does not apply to any DBHDS entity.	n/a	n/a							
Manage Contractor Communication	The Manage Contractor Communication business process receives requests for information, appointments and assistance from contractor such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed and produced for distribution via the Send Outbound Transaction process. NOTE: Inquiries from prospective and current contractors are handled by the Manage Contractor Communication process by providing assistance and responses to individual entities, i.e., bi-directional communication. The Perform Contractor Outreach process targets both prospective and current contractor populations for distribution of information regarding programs, policies and other issues.									
	This business process does not apply to any DBHDS entity.	n/a	n/a							

GOVERNOR'S CONFIDENTIAL WORKING PAPERS

ATTACHMENT E

Virginia Medicaid Enterprise Architecture (MEA)

MITA Technical Capabilities Matrix

Attachment E

Strategy Version 6

May 2011

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Agenda

- MITA Strategy
- Current Conceptual Architecture
- Steps to MEA
- Transition to MEA

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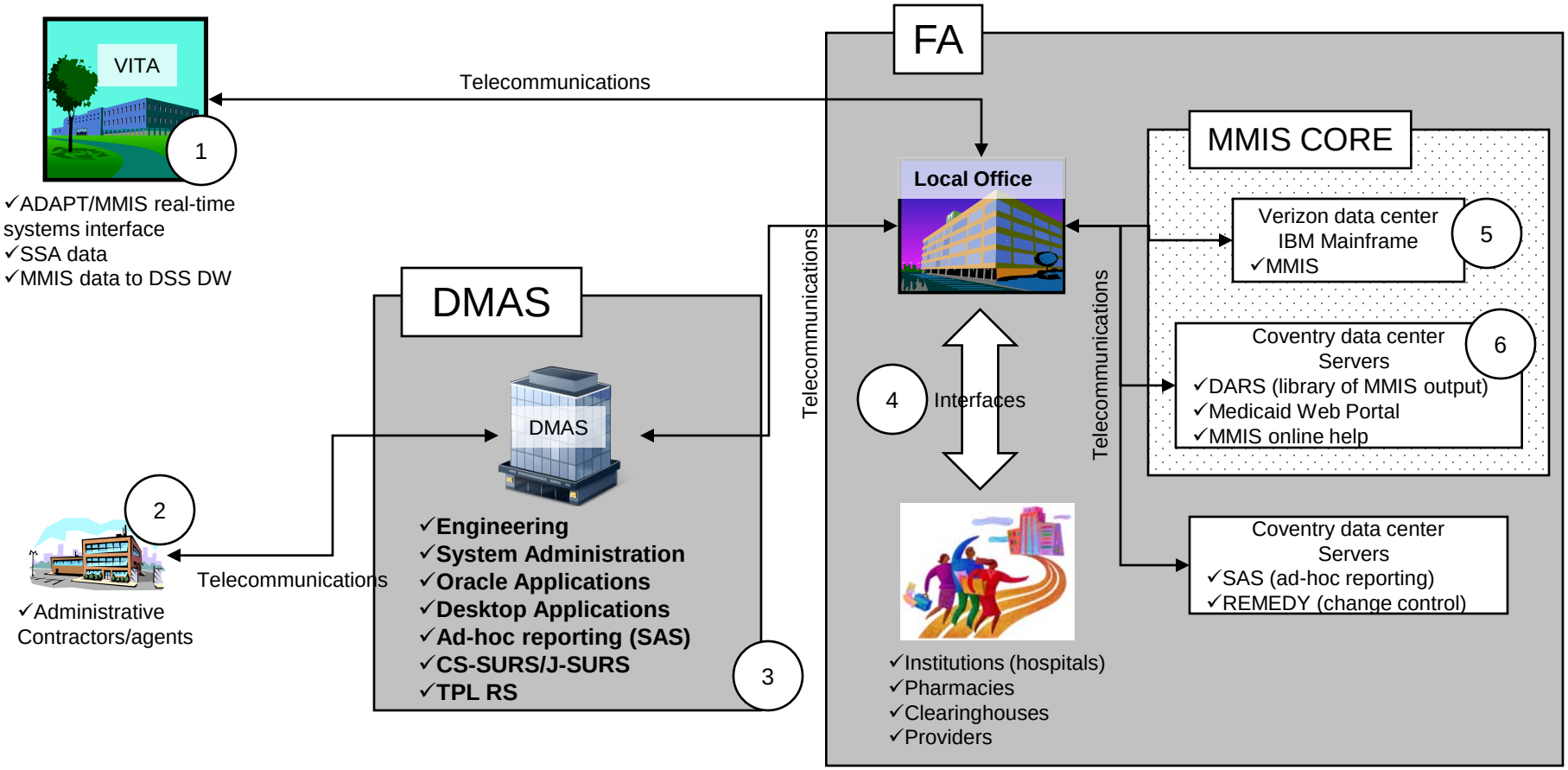
MITA Strategy

Strategic, business, and technical alignment

- Repeat State Self Assessment (SS-A) every two years
  - Align/Realign Virginia's effort with MITA Direction
    - Strategic, Business, legislative, Technical (MEA), MITA Industry Standards.
  - Identify gaps and take action
    - Vision for MITA implementations
      - Series of multi-agency process improvement efforts.
      - Efforts selected from SS-A Business Capability Matrix (BCM) and the availability of needed MITA process, business services, and data standards.
- Leverage Virginia's efforts
  - Business
    - Strategic Planning for Enterprise Applications (Virginia Enterprise Applications Program Agency)
      - Using COV Enterprise applications, identified Enterprise COTS products, shared services, and governance.
      - Key partner for MITA collaborative efforts.
    - Enterprise Architecture (Virginia Information Technology Agency)
      - Business architecture and alignment to technology.
  - Technical
    - Enterprise Architecture (Virginia Information Technology Agency)
      - Using COV Policies, Standards, and Guidelines.
  - Communication/Stakeholders
    - Use standing COV working groups, committees, councils, and user groups to educate, convey information, collaborate, and coordinate efforts.
    - Use standing medical and pharmacy industry association and directed provider/pharmacy relationships.
- Virginia Medicaid Enterprise Architecture
  - A conceptual vision of current and evolving MITA and COV policy, guidelines, and standards applied to state and contracted assets (business, technology, data) that support the Medicaid Program.

Current Conceptual Architecture



Current Conceptual Architecture (Cont'd)

1	Currently, VITA data center has dedicated T1 TCP/IP circuits terminated ACS to support DSS ADAPT/MMIS real-time systems interface. Also used for SSA data exchanges and output data to VDSS as well as web connectivity to the MMIS for DSS/LDSS eligibility operations (~4K users).
2	Some of DMAS contractors/Agents connect to DMAS to access the Core MMIS components for performing their functions.
3	FA provides staff for: network engineering, help desk, desktop automation support, ad-hoc reporting via SAS, system administration (Unix operating system for IBM/AIX and HP/UX), Oracle Data base administrator (DBA), desk top technical support as well as MMIS components: Third Party Liability Recovery System (TPL RS), Client Server/Java Surveillance and Utilization Review (CS-SURS/J-SURS), Statistical Analysis System (SAS) file server. Other applications include Oracle Government Financial System (GFS), assorted Oracle and MS Access applications, and SAS.
4	FA has established business associate agreements with a variety of external trading partners. In addition, the FA supports the interfaces, testing, and associated processing (HIPAA ANSI X12 EDI transaction sets, custom interface files etc.)
5	MMIS (Cobol/DB2) environments are outsourced to a Verizon mainframe in Tampa Bay, FL. Connectivity hub for Virginia is currently via ACS. Other environments are provided for VDSS testing and training. MMIS supports 22X7 for pharmacy claims processing (2 hour daily system maintenance window). MMIS user hours: 06:15AM-8PM Monday-Friday, 06:15AM-2PM Saturdays.
6	ACS data center in Tarrytown, NY houses most of the ancillary servers for the FA and Core MMIS Technologies; Document Archival and Retrieval System (DARS), the electronic library of MMIS outputs (letters/reports); Remedy (used for CM system); MMIS Online help; Virginia Medicaid Web Portal, and SAS servers.

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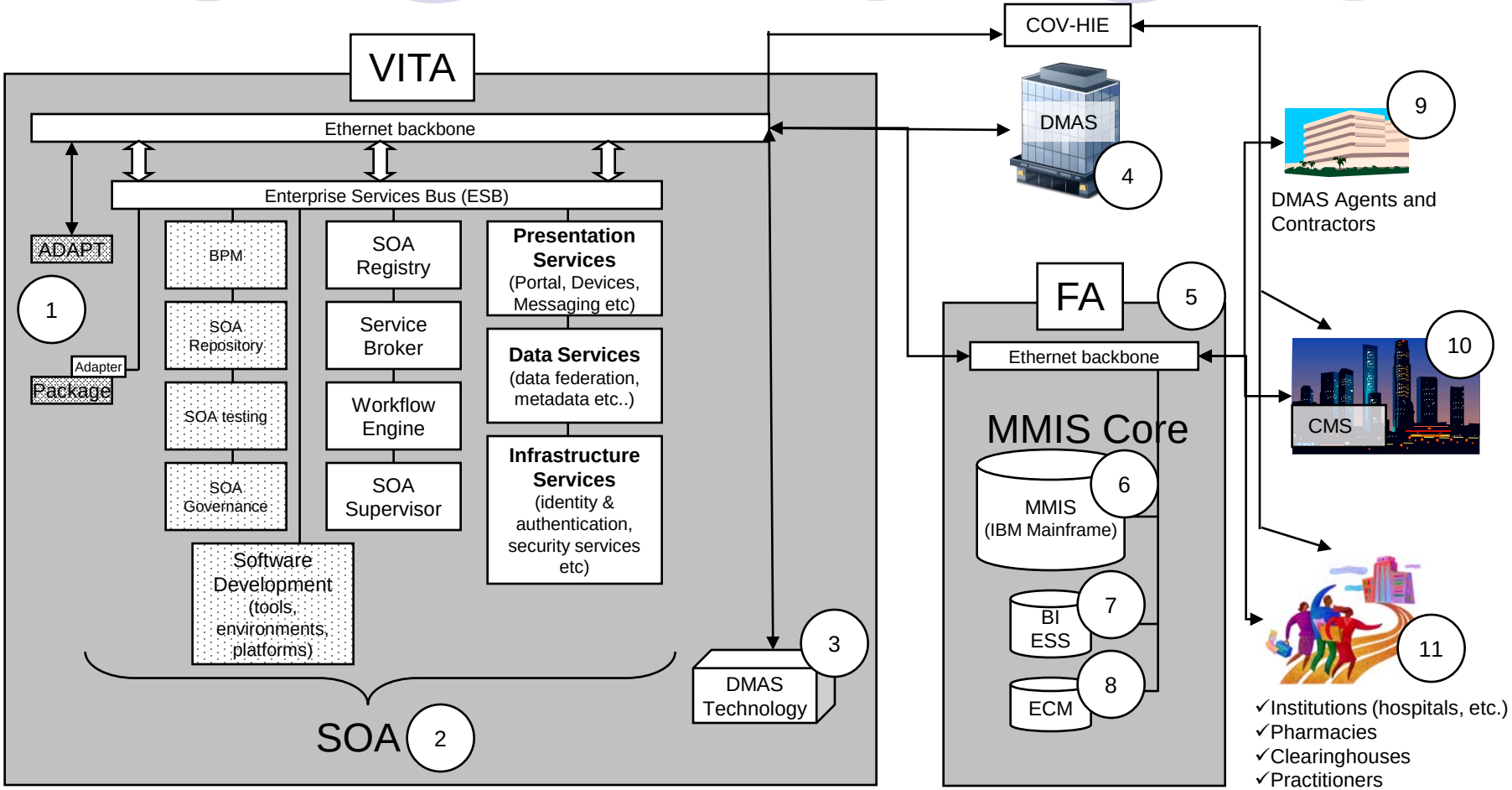
Steps to MEA

SS-A technical alignment

- Steps to MEA
  - Step 1: Position Technology for MITA Alignment
  - Step 2: Define MITA standard interface SOA adaptors – External to MMIS
  - Step 3: Use MITA standard interface SOA adapters - Internal to MMIS
  - Step 4: As business needs dictate, replace MMIS subsystem/components
- Note: The following ***conceptual*** diagrams are ***not intended*** to imply any scheduling/ timeframes and/or specific technical details

MEA

Step 1: Position Technology For MITA Alignment



Note: Does not imply any scheduling, priorities, dependencies, specific products, or timeframe

MEA

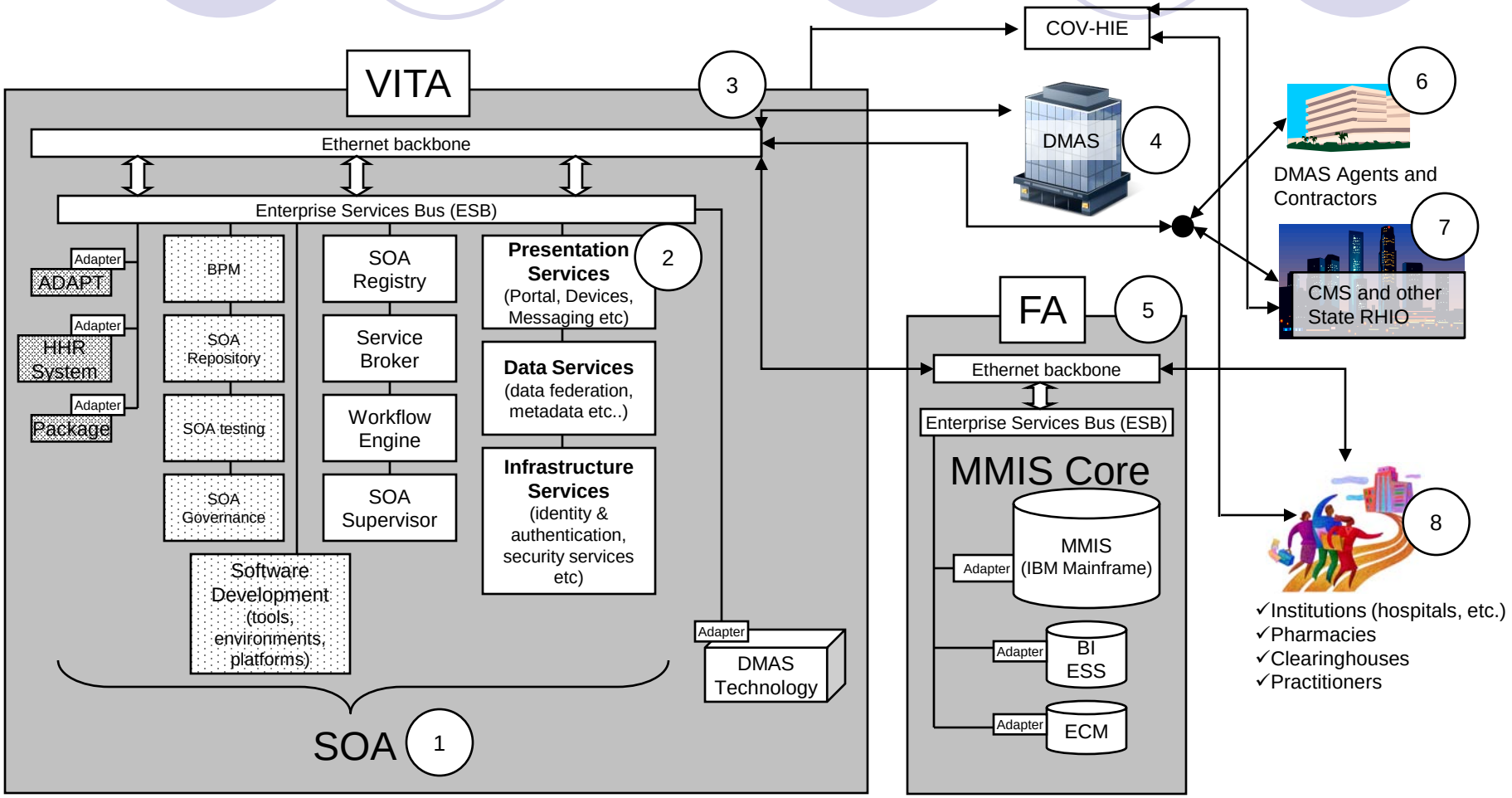
Step 1: Position Technology For MITA Alignment (Cont'd)

1	Application/system interfaces to SOA are accomplished via "adapters" that translate web based messages [Extensible Markup Language (XML)] between the SOA and legacy architectures using MITA standard service and data standards. Using SOA "adapters" legacy systems can be connected without immediate replacement of the legacy systems/COTS packages. This step does not interconnect COV applications via SOA.
2	Represents conceptually the pieces and parts of a SOA (complex undertaking). Not intended to represent what currently exists at VITA (some components are in place). What this step entails is jointly reviewing (DMAS/VITA/VEAP/VDSS) in detail the suitability of the existing infrastructure to support the MEA. Particular emphasis on Governance needs to be detailed as well as framing the performing SOA organization/contractor for the development needs for adapters, workflow, and data transformation. DMAS will participate in COV efforts to define a Strategic Enterprise Application Plan, enterprise COTS products as well as COV shared services. The current IAG process needs to be modified (a MITA business process) to produce an enforceable SLAs with cost and service level accountability for all participants in the ME. This step also initiates a COV MITA awareness effort and the subsequent discussions as well as processes to procure tools, environments, and other management infrastructures needed for a future SOA solution.
3	The DMAS technical environment and support is the responsibility of VITA. DMAS retains application development and maintenance responsibility for Agency unique Oracle GFS, Oracle and other desktop applications as well as MMIS components on COV technology platforms (TPL RS, CS-SURS/J-SURS, SAS).
4	FA provides development support for DMAS Technology Agency unique applications on the desktop, Oracle apps, Oracle GFS, and SAS. User access methods to FA and Core MMIS components remain unchanged from current methods.
5	FA maintains MMIS legacy (CICS, Cobol, DB2) software using DMAS mandated Software Development Life Cycle (SDLC) processes. FA provides primary help desk function for FA and Core MMIS Technologies. This step does not connect the MMIS and its pieces and parts to SOA.
6	Client builder GUI is replaced by web screens (CICS screens not re-engineered); web based claims DDE and provider enrollment capabilities added.
7	Business Intelligence (BI) products containing a Data Warehouse (DW) with an Executive Support System (ESS) /Decision Support System (DSS) implemented using COV specified enterprise COTS products.
8	Existing disparate document management solutions are consolidated into an Enterprise Content Management (ECM) solution using the COV specified ECM product (IBM filenet). Minimal workflows implemented in ECM; MITA workflows, as extended for COV needs, are implemented using SOA workflow tools.
9	DMAS Agents and contractors connect to FA for access to MMIS.
10	CMS and other Federal Agencies access to FA and Core MMIS components remain unchanged from current methods.
11	FA hosts and support all necessary vendor relationships [Health Insurance Portability and Accountability Action (HIPAA) Business Associate Agreements (BAA] as well as the technical support necessary for HIPAA ANSI X12 standard transaction sets.

Note: Does not imply any scheduling, priorities, dependencies, or specific products.

MEA

Step 2: Define MITA standard interface SOA adaptors – External to MMIS (Eligibility Systems)



Note: Does not imply any scheduling, priorities, dependencies, specific products, or time frames.

MEA

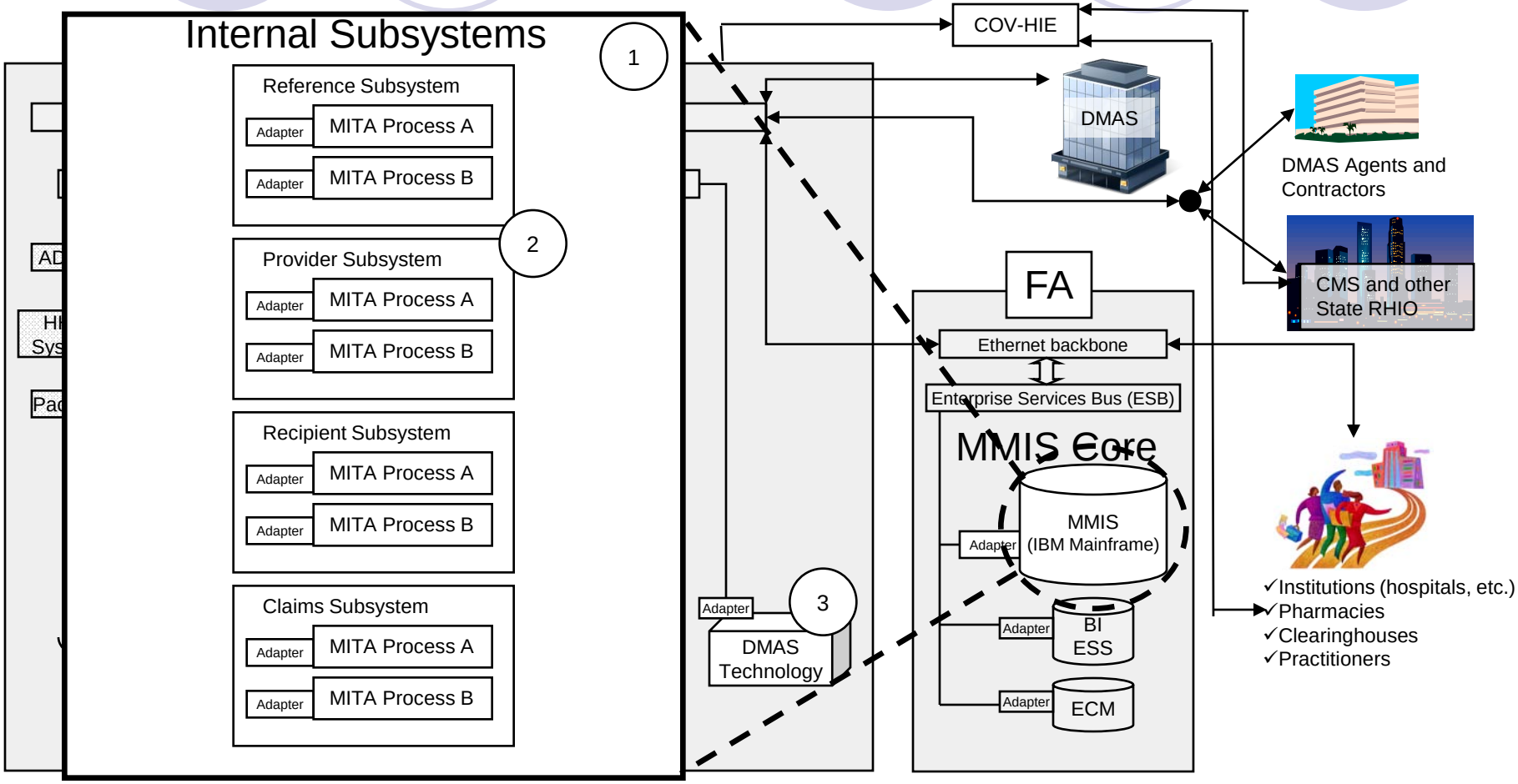
Step 2: Define MITA standard interface SOA adaptors – External to MMIS (Cont'd)

1	The MMIS components are directly interacting via SOA services (DMAS Agency unique applications, DSS ADAPT etc..). The Virginia Medicaid Enterprise Regional Health Information Organization (RHIO) core hub begins to function (compliant with MITA standards, legislation, and direction current at that point in time).
2	SOA presentation services takes over portal responsibility for MEA. Medicaid Enterprise Services and Data presented in real time from SOA interfaced systems and MITA process workflow. Use of Personal Digital Assistant (PDA) and other electronic presentation devices (smart phones etc) now possible.
3	A pilot project is chartered to construct interface "adapters" for supporting MITA standard business services, data, and workflow. The MMIS subsystems are not modified to exclusively use SOA interface "adaptors" internally. The MMIS claims subsystem is modified to process all claim types (including assessments) in real-time matching the availability of the pharmacy Point of Sale (POS) (22 X7) [2 hour daily systems maintenance window]. Financial transactions continue the weekly remittance cycles or can be converted to real time account credit/debit transactions. After the pilot, additional process improvement projects are chosen based on the biennial Virginia MITA State Self Assessment gap analysis and availability of requisite MITA standards. A COV central ME workflow development and maintenance capability is established. A series of process improvement projects will make profound changes to operational, organization, and business process and procedures. Operational, business process, organizational, and workforce transformation begins.
4	DMAS technical environment responsibility of VITA. DMAS retains application development and maintenance responsibility for Agency unique Oracle GFS, Oracle and other desktop applications as well as MMIS components on VITA platforms (TPL RS, CS-SURS/J-SURS, SAS). DMAS users begin to transition to using Medicaid Enterprise workflows as they are ready; direct use of MMIS web based CICS screens begins to decline. Operational, business process, organizational, and workforce transformation begins.
5	FA establishes COV specified/compatible SOA technology and connects FA ESB to VITA ESB. Participates in SOA adapter construction (Legacy MMIS side of interface) as well as modification to the MMIS claims processing subsystem. MMIS subsystems and components are retired.
6	DMAS Agents and contractors connect to VITA to access the MEA.
7	FA contractor maintains legacy business relationships with trading partners. As trading partners, CMS, and other authorized RHIOs are ready to transition to MITA standard interfaces they are connected to VITA and the MEA hub.
8	Contractor continues to host and support all necessary legacy vendor relationships (HIPAA BAA etc.) as well as the technical support necessary for HIPAA ANSI X12 standard transaction sets. DMAS business and technical outreach activities intensify with external trading partners for the Virginia Medicaid Enterprise. Connection of trading partners to the SOA Enterprise Services Bus (ESB) begins as they are ready. Other trading partner Regional Health Information Organization (RHIO) hubs starts to emerge and establish direct connectivity to MEA.

Note: Does not imply any scheduling, priorities, dependencies, specific products, or time frames.

MEA

Step 3: Define MITA standard interface SOA adaptors – Internal to MMIS



Note 1: Does not imply any scheduling, priorities, dependencies, specific products, or time frames.

Note 2: Approach for this step is to remove internal MMIS dependencies. However, some restructuring may not be required or was accomplished in previous step.

MEA

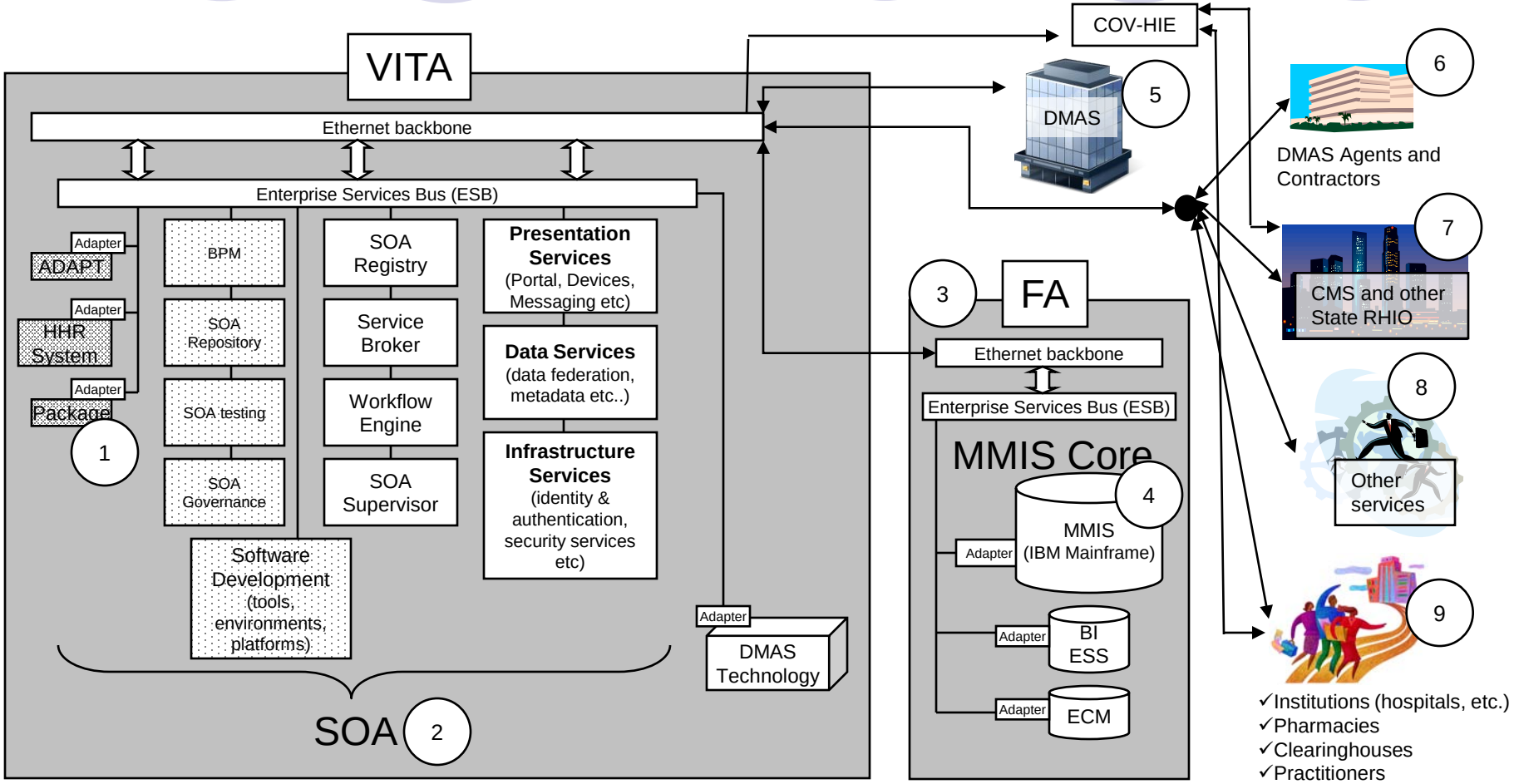
Step 3: Use MITA standard interface SOA adapters - Internal to MMIS (Cont'd)

1	All MMIS subsystems are evaluated and where appropriate, modified to use MITA standard business service interface adapters and communicate via the SOA only. Where appropriate, legacy inter-subsystem and/or inter-process dependencies are removed. This step provides the capability to upgrade/replace MMIS parts by other MITA standard best-in-class applications/services as DMAS business needs dictate. Users transition to MITA standard web workflows; direct use of MMIS screens decline. Operational, business process, organizational, and workforce transformation continues.
2	Where appropriate, each MMIS legacy subsystems are modified to communicate outside of the standard interfaces on SOA. All financial transactions support real time account credit/debit.
3	DMAS Agency specific legacy applications go through a similar process. Operational, business process, organizational, and workforce transformation continues.

Note: Does not imply any scheduling, priorities, dependencies, specific products, or time frames.

MEA

Step 4: As business needs dictate, replace MMIS subsystem/components



Note: Does not imply any scheduling, priorities, dependencies, specific products, or time frames

MEA

Step 4: As business needs dictate, replace MMIS subsystem/components (Cont'd)

1	All COV Executive Branch Enterprise and Agency specific applications supporting the Medicaid program use MITA compliant data standards, interfaces, and workflows.
2	Virginia Medicaid Enterprise is fully MITA compliant and operational. Centralized support and maintence for MITA compliant workflows and COV extensions exist. Use of PDA and other electronic presentation devices (smart phones etc) are in use. The Regional Health Information Organization (RHIO) central hub continues to expand as additional federal, regional, state and local governments, and trading partner RHIO hubs establish connectivity with appropriate business agreements (data sharing/privacy/security etc.)
3	FA hosted MMIS components have been constructed using COV specified COTS products.
4	All MMIS components use MITA compliant interfaces and can be replaced individually with other MITA compliant best-in-class applications as business needs dictate. FA continues to maintain MMIS components that have not been retired.
5	DMAS interacting with Medicaid Enterprise via MITA standard web interfaces and workflows for most users. Some use of MMIS legacy web enabled CICS screens remain in use.
6	DMAS Agents and contractors establish access to MEA by connecting to VITA.
7	DMAS business and technical outreach activities intensify with external trading partners for the Virginia Medicaid Enterprise. Connection of trading partners to the VITA SOA ESB begins as they are ready. Other trading partner Regional Health Information Organization (RHIO) hubs starts to emerge and establish direct connectivity to MEA. Interoperability with Federal and other regional States RHIOs possible.
8	Additional services from external vendors can be procured for the RHIO as business needs dictate (replacing a legacy MMIS component/subsystem for example).
9	DMAS business and technical outreach activities continue with external trading partners for the Virginia Medicaid Enterprise. Connection of trading partners to the VITA SOA ESB continues as they are ready.

Note: Does not imply any scheduling, priorities, dependencies, specific products, or time frames.

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Transition to MEA

Note: Does not imply any specific scheduling, priorities, or dependencies

Step	CY2007	CY2008	CY2009	CY2010	CY2011	CY2012	CY2013	CY2014	CY2015
Step 1: Position Technology for MITA Alignment	SS-A	Planning* (APD) , procurement, migration							
Step 2: Define MITA standard interface SOA adaptors – External to MMIS			SS-A	Planning (APD) ,initiate projects					
Step 3: Use MITA standard interface SOA adapters - Internal to MMIS					SS-A	Planning (APD) ,initiate projects			
Step 4: As business needs dictate, replace MMIS subsystem/components							SS-A	Routine MITA alignment cycles	SS-A**

MEA Operational

Notes:
*Planning involves detailed planning for the MEA SOA (governance, SOA technology, contracting/SLA) with VEAP, VITA, and other key Commonwealth stakeholders.
**SS-A alignment process repeated every two years to remain in alignment with MITA and CMS. The SS-A will drive what new actions/projects need to be defined and may alter this timeline.

Assumptions:
1. VEAP and VITA are active partners in MITA activities.
2. Virginia strategic planning aligns with MITA at all levels (Governor, Secretariat, and Agencies).
3. MITA information and service standards for adapters/interfaces as well as workflows are defined. It is likely that these will be emerging standards and DMAS should plan for an active participation in the standards working groups by technical resources (may not be DMAS staff) assigned to the MEA.
4. SS-A identified business process improvement efforts/projects are conducted in parallel with the MEA transition. The MEA will be an enabler for a number of transformational business process improvement efforts/projects. Close coordination in this area will be necessary.
5. External factors do not impact timeline.
6. Future DMAS SS-A efforts or changes to MITA framework by CMS or industry will not impact timeline.