DHS-IME Procurement Project
Iowa Medicaid Enterprise
Medicaid Information Technology Architecture
State Self-Assessment Report

Authorized for issue by:

Mary Tavegia **Iowa Medicaid Enterprise (IME)** **Project Director**	**Signature**	**Date**
Tom Mologianes **FOX Systems, Inc. (FOX)** **Project Manager**	**Signature**	**Date**

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Revision History

Version Number	Date	Reviewer	Comments
Version 0.1	May 21, 2009	FOX Team	Deliverable Draft
Version 1.0	June 1, 2009	FOX Team	Final

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List of Figures and Tables

1.0 Executive Summary

1.1 Deliverable Document Overview

This document is organized in five major sections:

- **Executive Summary** – Briefly presents the main topics discussed in the document.
- **Iowa Medicaid Enterprise (IME) Medicaid Information Technology Architecture (MITA) Project Overview** – Describes the overall MITA project in more detail than in the Executive Summary.
- **Key Findings** – Presents the results of the As-Is Assessment at the business process (BP)/technical function (TF) level, though in more detail than in the Executive Summary. This includes the As-Is maturity assessment for each BP and TF.
- **IME Priorities and MITA To-Be Vision** – Discusses IME efforts already under way, and addresses the priorities identified by IME in their vision for the future.
- **Appendices** – Contain additional detail to support the key findings of the assessment.

1.2 MITA Overview

Medicaid Information Technology Architecture (MITA) is a business initiative of the Centers for Medicare and Medicaid Services (CMS) in cooperation with State programs. It is intended to stimulate an integrated business and technological transformation of the Medicaid enterprise in all states. MITA can improve Medicaid program administration by aligning business processes and supporting technology with national guidelines. The MITA Framework is a consolidation of principles, business and technical models, and guidelines that provides a template for states to use in development of their individual enterprise architectures. It is utilized in a manner that is consistent with CMS' expectations. In the future, MITA guidelines will support states' requests for appropriate Federal financial participation (FFP) for their Medicaid Management Information Systems (MMIS).

MITA is intended to provide a business and information architecture that states can use as a framework for improving Medicaid and exchanging data throughout the enterprise. Affected stakeholders might include beneficiaries, vendors and service providers, State and Federal Medicaid agencies, and other agencies and programs that are supported by Federal matching funds.

MITA identifies common Medicaid business processes and seeks to convert them into web services. Web services encompass standards that enable automated applications to communicate and exchange data over the Internet (or Intranet) across many sites and organizations. The development of common data and information standards allows interoperability across different platforms, integration of applications, and modular programming, so that changes can be introduced incrementally and existing information assets can be leveraged. MITA entails far

more than paying and documenting claims; it envisions significant business processing, information, and technical changes including:

- Improvements in monitoring programs and the quality of care through data sharing across the Medicaid enterprise
- Efficient use of resources through sharing reusable software
- More timely responses to program changes and emerging health needs
- Improved access to high-quality information, so that patients and providers can make more informed decisions about health care

This transformation is profound because of the scope of necessary business and technology changes required, and the fact that some required technologies have not yet fully evolved. Some changes can be made in two to three years, but others will take five to ten years.

1.3 IME State Self-Assessment

1.3.1 Background

The IME MITA Enterprise Architecture assessment included:

- Business Process As-Is Assessment and Validation
- Systems and Technology As-Is Assessment [Technical Assessment (TA)]
- Targeted To-Be Business Process Planning

The State Self-Assessment (SS-A) consists of two components: the business and technical assessments. An overview of the steps involved in the IME SS-A can be found in the IME State Self-Assessment Overview diagram, below.

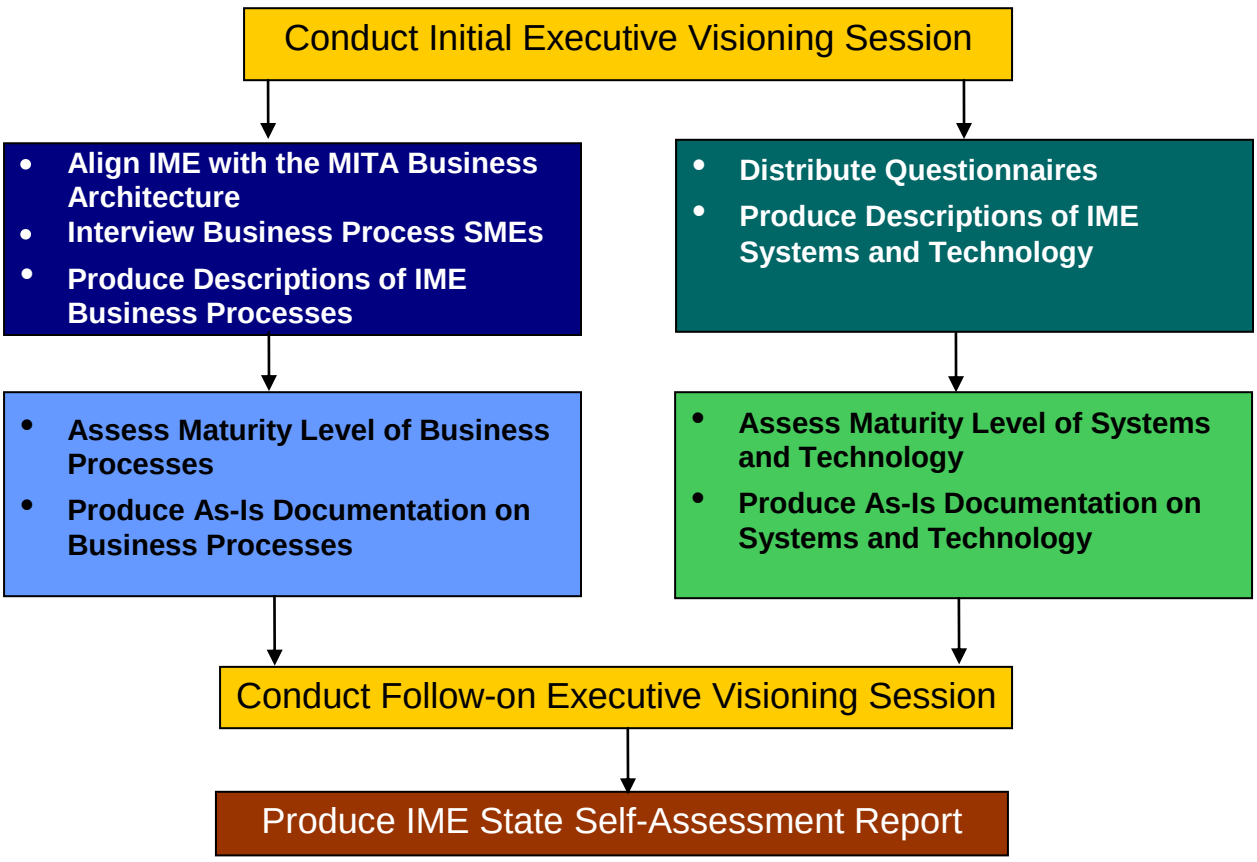

Figure 1 IME State Self-Assessment Project Overview

The results of the business assessment, i.e., the mapping, assessment, and description of the IME business against the MITA 2.0 Framework (79 processes in 8 key areas) are documented in section 3.2.1 IME As-Is Business Process Architecture of this report. The mapping exercise resulted in the identification of one Iowa-specific business process. Assessment and description of this Iowa-specific process is included in section 3.2.1. The results of the Systems and Technology As-Is Assessment (TA), which assessed IME's technical maturity, are documented in section 3.2.2 IME As-Is Technical Architecture. The Targeted To-Be Business Process Planning is addressed in section 4.0.

1.3.2 Participants

Participants and subject matter experts (SMEs) in the MITA SS-A of the project were identified with the assistance of IME project executives and management. The following tables document the participants in the Technical Assessment, Maturity Assessment and the Visioning Sessions.

For a listing of all Participants in the Business Process Assessment sessions, see Appendix A of this report.

Table 1 Systems and Technology As-Is Assessment Participants

IME Participants	Position
John Davis	Account Manager
Sandra Pranger	POS Account Manager
Scott Hruska	Account Manager
Jody Holmes	CORE Unit Manager
Randy Clemenson	DW
Andrea Dykstra	Account Manager – Medical/ Pharmacy
Russ Rozinek	Data Center Manager

Table 2 Maturity Assessment Sessions Participants

IME Participants	Position
Jennifer Steenblock	Unit Manager
Alisa Horn	Assistant Division Director
Patti Ernst-Becker	Unit Manager
Mary Tavegia	IME Project Director, IME Unit Manager
Kelly Metz	Policy
Eileen Creager	Unit Manager
Julie Lovelady	Policy
Deb Johnson	Unit Manager
Jody Holmes	Unit Manager
Brad Neuweg	Fiscal Management
Joe Havig	Fiscal Management

The Executive Visioning sessions for the Division were conducted on December 9, 2008 and April 7, 2009. Participants included the following IME management staff.

Table 3 Participants in the December 9, 2008 Executive Visioning Session

IME Participants	Position
Jennifer Steenblock	Unit Manager, IME
Alisa Horn	Assistant to Medicaid Director
Patti Ernst-Becker	Unit Manager, IME
Mary Tavegia	IME Project Director, IME Unit Manager
Dennis Janssen	Bureau Chief, IME
Eileen Creager	Unit Manager, IME
Jennifer Vermeer	Director, Medicaid
Deb Johnson	Unit Manager, IME
Jody Holmes	Unit Manager, IME

Table 4 Participants in the April 7, 2009 Executive Visioning Session

IME Participants	Position
Julie Lovelady	Deputy Medicaid Director
Mary Tavegia	IME Project Director, IME Unit Manager
Jennifer Vermeer	Medicaid Director

1.4 Summary of Key Findings

1.4.1 Aligning the IME Vision with the MITA Vision

One of the key elements of MITA is the consideration of mission and vision principles for the Medicaid Program, other State agencies, and the overall goals of the State's government. The IME Planning Team held Executive Visioning Sessions facilitated by FOX on December 9, 2008 and April 7, 2009. The purpose of these sessions was to develop the guiding principles and objectives that would assist the IME Planning team in activities related to business and technical assessment of the Medicaid program.

In the course of these sessions, IME's senior management identified priorities for IME over the next 5 to 10 years. The following table demonstrates the alignment between the identified priorities and the goals and objectives as defined in the MITA Framework 2.0. The table condenses some of the IME priorities and abbreviates the wording of the IME priorities and MITA goals. The full text of both can be found in section 4.1.2 Vision and Priorities.

Table 5 Alignment of IME Priorities with MITA Goals

IME's Priorities	MITA Goals						
		(3) Promote an enterprise view	(2) Promote flexibility, adaptability, and changeability	(5) Provide performance metrics	(4) Provide timely, accurate, usable and accessible data	(1) Develop integrated systems	(6) Coordination with other partners
	Number of Priorities Matching a Goal	*8*	*7*	*7*	*6*	*4*	*4*
	1. Improved Web-based options for stakeholders		■		■	■	■
	2. Automated verification/credentialing	■			■	■	■
	3. Monitor contractor performance			■			
	4. Strategic Management	■	■	■			
	5. Training in program analysis	■	■	■			
	6. Medicaid Value Management			■			
	7. Improve data analysis – access, tools, resources	■			■		
	8. Improve member services						■
	9. Modular approach to replacing system functionality		■			■	
	10. Expansion of document management and workflow management capabilities	■			■	■	
	11. Improving waiver programs				■		
	12. Rules-based engine		■		■		
	13. Standardization of data and reports						
	14. Credentialed as a MCO						
	15. Expand Care Management	■					■
	16. Self-audit of Program Integrity			■			
	17. Program Integrity in every unit	■		■			
	18. Shifting the focus of Policy unit	■	■				
	19. Ongoing evaluation of Prior Authorization		■	■			

1.4.2 Summary of As-Is Business Process and Technical Assessments

This section summarizes the results of the As-Is assessments for both the IME MITA Enterprise Business and IT Architectures. The MITA Maturity Levels of each Business and Technical Area were assessed by the FOX team and confirmed by IME. The assessment was made utilizing the capabilities defined in the Framework 2.0[1] MITA Business Capability Matrix defined for each business process from Part I and the Technical Capabilities Matrix from Part III of the Framework. The information below reflects the As-Is maturity assessments of both the Business Areas and the IME IT architecture expressed at the Business Area and Technical Area level of the organization.

See Section 3.2.1.3 IME Business Process Descriptions and As-Is Maturity Assessments and Section 3.2.2.2 IME Technical Function Descriptions and As-Is Maturity Assessments for the specific maturity level of each capability within the IME MITA business processes and technical areas.

Table 6 As-Is Maturity Level Assessment at the Business Area Level

Business Area Name	Maturity Level Summary
Member Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 12.5% level 1 – 7 BPs – 87.5%
Provider Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 14.29% level 1 – 6 BPs – 85.71%
Contractor Management	This area as a whole is currently at level 1. The business processes within this area are at the following levels: level 2 – 1 BPs – 1.11% level 1 – 8 BPs – 88.89%

[1] The MITA Framework is constantly evolving. The overall Framework definition is at version 2.0. However, Business Process definitions have been updated and for these we utilized the version 2.01 definitions. The Business Capability definitions had not been updated as of the start of the project and these were assessed using the 2.0 version of the definitions.

Business Area Name	Maturity Level Summary
Operations Management	This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 12 BPs –46.15% level 1 – 13 BPs –53.85% Note: There are 26 Operations Management business processes, but one of these is not currently a part of the Iowa MITA Enterprise.
Program Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 4 BPs – 20% level 1 – 16 BPs – 80%
Business Relationship Management	This area has 4 BPs, all at level one level 1 – 4 BPs – 100%
Program Integrity Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 50% level 1 – 1 BPs – 50%
Care Management	This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 2 BPs – 66.67% level 1 – 1 BPs – 33.33% Note: There are four Care Management business processes but one of them is not currently a part of the Iowa MITA Enterprise.

Table 7 As-Is Maturity Assessment at the Technical Area Level

Technical Area	Maturity Level Summary
Business Enabling Services	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 5 – 45.45% level 1 – 6 – 54.55%
Access Channels	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 1 – 2 – 100%
Interoperability	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 20% level 1 – 4 – 80%

Technical Area	Maturity Level Summary
Data Management and Sharing	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 1 – 2 – 100%
Performance Measurement	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 1– 50% level 1 – 1– 50%
Security and Privacy	This area is currently at level one IME does not currently perform one technical process , Intrusion Detection The technical functions within this area are at the following levels: level 2 – 3 – 60% level 1 – 2 – 40%
Flexibility – Adaptability and Extensibility	This area is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 25% level 1 – 3 – 75%

The following figure pictorially illustrates the assessed As-Is Maturity Levels of IME business processes at the Business Area level of the MITA enterprise. The source data are the contents of the above tables.

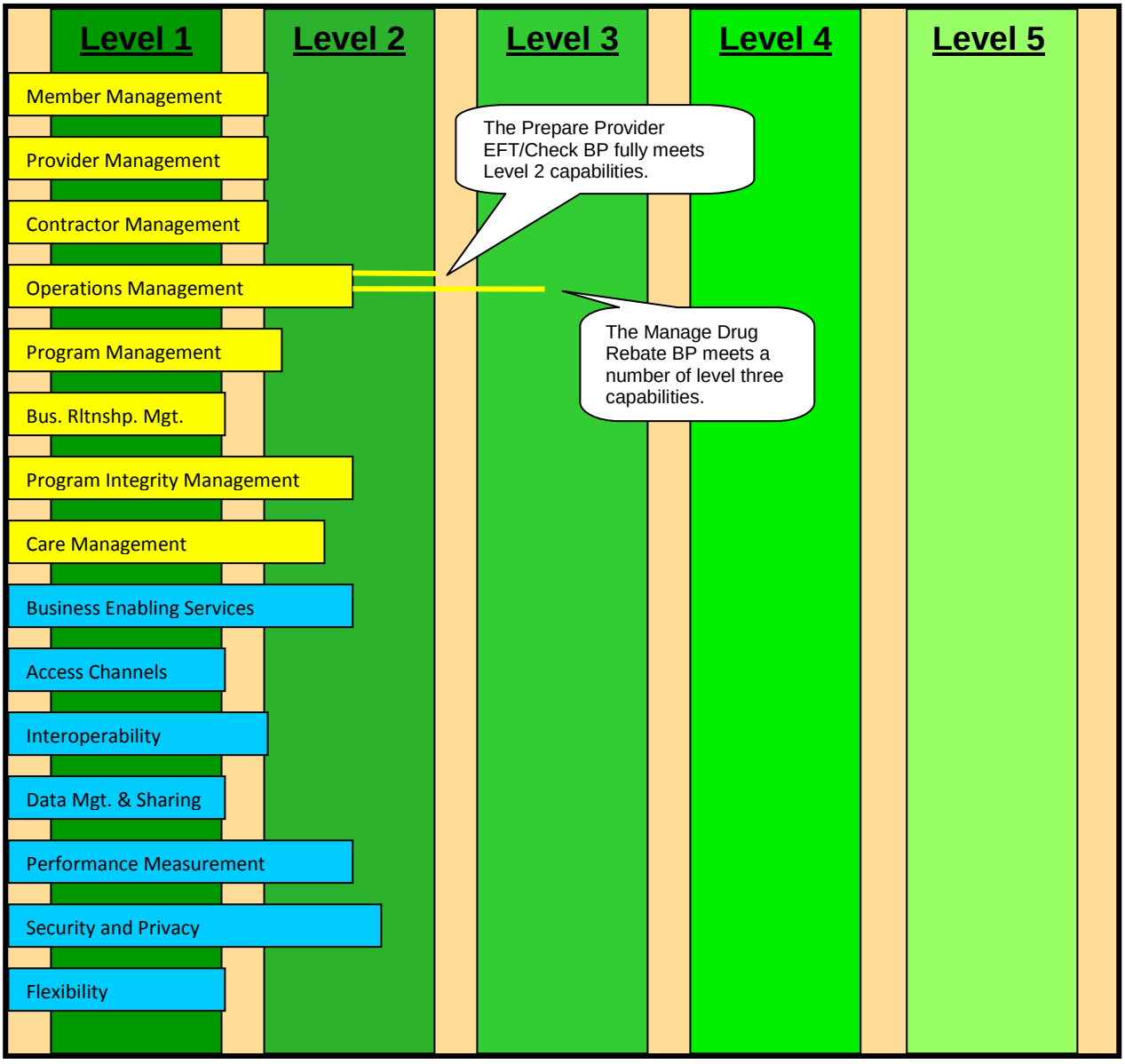

Figure 2 Business Area and Technical Area Maturity Levels

1.4.3 Summary of the IME To-Be Assessment

The following table summarizes at the Business Area level, the To-Be MITA Maturity Levels targeted by the IME Planning Committee as part of the SS-A. Section 4.2.1 Business Process As-Is and To-Be Maturity Levels contains a table with the Maturity Levels for each Business Process.

Table 8 To-Be Maturity Assessment at the Business Area Level

Business Area Name	Maturity Level Summary
Member Management	The Maturity Level of this area, as a whole, would be level 2 once enhancements to the process meet the specified To-be capabilities for the individual processes have been implemented. The business processes within this area have been assessed the following To-Be maturity levels: level 3 – 3 BPs –37.5% level 2 – 5 BPs – 62.5%
Provider Management	The Maturity Level of this area, as a whole, would be level 2 once enhancements to the process meet the specified To-be capabilities for the individual processes have been implemented. The business processes within this area have been assessed the following To-Be maturity levels: level 3 – 1 BPs – 14.29% level 2 – 6 BPs – 85.71%
Contractor Management	The Maturity Level of this area, as a whole, would be level 2 once enhancements to the process meet the specified To-be capabilities for the individual processes have been implemented. The business processes within this area have been assessed the following To-Be maturity levels: level 3 – 1 BPs – 1.11% level 2 – 8 BPs – 88.89%
Operations Management	The Maturity Level of this area, as a whole, would still be level 1, as one process is not moving beyond this level. The business processes within this area have been assessed the following To-Be maturity levels: level 3 – 14 BPs – 56% level 2 – 10 BPs – 40% level 1 – 1 BP - 4% Note: There are twenty six Operations Management business processes but IME does not perform one of them.
Program Management	The Maturity Level of this area, as a whole, would be level 2 once enhancements to the process meet the specified To-be capabilities for the individual processes have been implemented. The business processes within this area have been assessed the following To-Be maturity levels: level 3 – 5 BPs – 25% level 2 – 154 BPs – 75%

Business Area Name	Maturity Level Summary
Business Relationship Management	The Maturity Level of this area, as a whole, would be level 2 once enhancements to the process meet the specified To-be capabilities for the individual processes have been implemented. This area has 4 BP, all have been assessed the following To-Be maturity level: level 2 – 4 BPs – 100%
Program Integrity Management	The Maturity Level of this area, as a whole, would be level 2 once enhancements to the process meet the specified To-be capabilities for the individual processes have been implemented. The business processes within this area have been assessed the following To-Be maturity levels: level 3 – 1 BPs – 50% level 2 – 1 BPs – 50%
Care Management	The Maturity Level of this area, as a whole, would be level 2 once enhancements to the process meet the specified To-be capabilities for the individual processes have been implemented. The business processes within this area have been assessed the following To-Be maturity levels: level 3 – 2 BPs – 66.67% level 2 – 1 BPs – 33.33% Note: There are four Care Management business processes but IME does not perform one of them.

2.0 IME MITA Project Overview

2.1 State Self-Assessment Scope and Approach

The goal of the State Self-Assessment (SS-A) was to assess and document the IME's Business Architecture, including As-Is descriptions of all Business Processes (BPs), the As-Is Maturity Level of those processes, As-Is systems and technology, and the target To-Be Maturity Levels of the IME Business Processes over the next 5 to 10 years.

The tasks associated with this scope of work included the following major areas:

- Documenting IME Vision, Mission, and Goals
- Mapping IME BPs to the MITA Framework BPs
- Documenting the IME As-Is BPs
- Documenting the IME Systems and Technology
- Assessing the As-Is Maturity Level for IME BPs
- Identifying a To-Be Maturity Level for each IME BPs
- Documenting the Self-Assessment Findings and Recommendations

2.2 Assessment Process

FOX worked with the IME Planning Team to establish the processes and procedures to support the IME SS-A. This included enlisting the support of key stakeholders, management, and subject matter experts (SME) throughout the State's MITA business and technology enterprise(s). These individuals participated in the development of the BP descriptions and As-Is Maturity Assessments listed in Section 3.2.1.3 IME Business Process Descriptions and As-Is Maturity Assessments of this report. The processes employed to develop the descriptions included:

- Mapping of the IME organization to the MITA Business Architecture
- Planning, conducting, and facilitating sessions to develop BP descriptions and an informal To-Be list of future improvements
- Performing a preliminary assessment of the IME As-Is BP descriptions and the informal lists of To-Be improvements against the MITA Maturity Model to assign a proposed As-Is and To-Be Maturity level for each BP (FOX performed this step)
- Reviewing the preliminary Maturity assessment with the IME Planning Team to confirm or modify the results

3.0 Key Findings

3.1 Aligning IME to MITA

One of the earliest steps in a MITA SS-A is the alignment of the State's organization with the MITA Business Architecture from the Framework. The following table displays the results of the alignment of Iowa's MITA Enterprise to the MITA business model, including IME BPs that did not align with a MITA BP.

Table 9 MITA to IME Business Process Crosswalk

MITA Business Area/ MITA Business Process	IME Business Process Number	IME Business Process
Member Management		
Determine Eligibility	ME01	Determine Eligibility
Enroll Member	ME02	Enroll Member
Disenroll Member	ME03	Disenroll Member
Inquire Member Eligibility	ME04	Inquire Member Eligibility
Manage Applicant and Member Communication	ME05	Manage Applicant and Member Communication
Manage Member Grievance and Appeal	ME06	Manage Member Grievance and Appeal
Manage Member Information	ME07	Manage Member Information
Perform Population & Member Outreach	ME08	Manage Population and Member Outreach
Provider Management		
Enroll Provider	PM01	Enroll Provider
Disenroll Provider	PM02	Disenroll Provider
Inquire Provider Information	PM03	Inquire Provider Information
Manage Provider Communication	PM04	Manage Provider Communication
Manage Provider Grievance and Appeal	PM05	Manage Provider Grievance and Appeal
Manage Provider Information	PM06	Manage Provider Information
Perform Provider Outreach	PM07	Perform Provider Outreach
Contractor Management		
Produce Administrative or Health Services RFP	CO01	Produce Administrative or Health Services RFP
Award Administrative or Health Services Contract	CO02	Award Administrative or Health Services Contract
Manage Administrative or Health Services Contract	CO03	Manage Administrative or Health

MITA Business Area/ MITA Business Process	IME Business Process Number	IME Business Process
		Services Contract
Close-Out Administrative or Health Services Contract	CO04	Close-out Administrative or Health Services Contract
Manage Contractor Information	CO05	Manage Contractor Information
Manage Contractor Communication	CO06	Manage Contractor Communication
Perform Contractor Outreach	CO07	Perform Contractor Outreach
Support Contractor Grievance or Appeal	CO08	Support Contractor Grievance or Appeal
Inquire Contractor Information	CO09	Inquire Contractor Information
Operations Management		
Authorize Referral	OM01	Authorize Referral
Authorize Service	OM02	Authorize Service
Authorize Treatment Plan	OM03	Authorize Treatment Plan
Apply Claim Attachment	OM04	Apply Claim Attachment
Apply Mass Adjustment	OM05	Apply Mass Adjustment
Edit Claims-Encounter	OM06	Edit Claims/Encounter
Audit Claim-Encounter	OM07	Audit Claim
Price Claim-Value Encounter	OM08	Price Claim/Value Encounter
Prepare Remittance Advice-Encounter Report	OM09	Prepare Remittance Advice/Encounter Report
Prepare Provider EFT-check	OM10	Prepare Provider EFT/check
Prepare COB	OM11	This process is not currently conducted by IME
Prepare EOB	OM12	Prepare EOB
Prepare Home and Community Based Services Payment	OM13	Prepare Home and Community Based Services Payment
Prepare Premium EFT-check	OM14	Prepare Premium EFT/check
Prepare Capitation Premium Payment	OM15	Prepare Capitation Premium Payment
Prepare Health Insurance Premium Payment	OM16	Prepare Health Insurance Premium Payment
Prepare Medicare Premium Payment	OM17	Prepare Medicare Premium Payment
Inquire Payment Status	OM18	Inquire Payment Status
Manage Payment Information	OM19	Manage Payment Information
Calculate Spend-Down Amount	OM20	Calculate Spend-Down Amount
Prepare Member Premium Invoice	OM21	Prepare Member Premium Invoice

MITA Business Area/ MITA Business Process	IME Business Process Number	IME Business Process
Manage Drug Rebate	OM22	Manage Drug Rebate
Manage Estate Recovery	OM23	Manage Estate Recovery
Manage Recoupment	OM24	Manage Recoupment
Manage Cost Settlement	OM25	Manage Cost Settlement
Manage TPL Recovery	OM26	Manage TPL Recovery
Program Management		
Designate Approved Service Drug Formulary	PG01	Designate Approved Service/Drug List
Develop and Maintain Benefit Package	PG02	Develop and Maintain Benefit Package
Manage Rate Setting	PG03	Manage Rate Setting
Develop Agency Goals and Objectives	PG04	Develop Agency Goals and Objectives
Develop and Maintain Program Policy	PG05	Develop and Maintain Program Policy
Maintain State Plan	PG06	Maintain State Plan
Formulate Budget	PG07	Formulate Budget
Manage FFP for MMIS	PG08	Manage FFP for MMIS
Manage F-Map	PG09	Manage F-Map
Manage State Funds	PG10	Manage State Funds
Manage 1099s	PG11	Manage 1099s
Generate Financial and Program Analysis Report	PG12	Generate Financial and Program Analysis Report
Maintain Benefits-Reference Information	PG13	Maintain Benefits/Reference Information
Manage Program Information	PG14	Manage Program Information
Perform Accounting Functions	PG15	Perform Accounting Functions
Develop and Manage Performance Measures and Reporting	PG16	Develop and Manage Performance Measures and Reporting
Monitor Performance and Business Activity	PG17	Monitor Performance and Business Activity
Draw and Report FFP	PG18	Draw and Report FFP
Manage FFP for Services	PG19	Manage FFP for Services
	PGIA01	Manage Legislative Communication
Business Relationship Management		
Establish Business Relationship	BR01	Establish Business Relationship
Manage Business Relationship	BR02	Manage Business Relationship

MITA Business Area/ MITA Business Process	IME Business Process Number	IME Business Process
Terminate Business Relationship	BR03	Terminate Business Relationship
Manage Business Relationship Communications	BR04	Manage Business Relationship Communications
Program Integrity Management		
Identify Candidate Case	PI01	Identify Candidate Case
Manage Case	PI02	Manage Program Integrity Case
Care Management		
Establish Case	CM01	Establish Case
Manage Case	CM02	Manage Care Management Case
Manage Medicaid Population Health	CM03	Manage Medicaid Population Health
Manage Registry	CM04	This process is not currently conducted by IME. All known health related registries are maintained outside of the IME. This process is

3.2 IME As-Is Assessment

3.2.1 IME As-Is Business Process Architecture

This section describes the As-Is Business Process Architecture at two levels. The first is at the summary level where the maturity level assessment results are gathered into a matrix. The second addresses each business process individually, and explains the reasoning behind the As-Is maturity level assessment. A high-level description of the five MITA Maturity Levels is also provided, as background to the assessment.

The As-Is Maturity Levels were determined by the IME Planning Committee. At the time the SS-A was performed, updates to the Framework 2.0 capabilities had not been released by CMS. For many of the processes, while FOX utilized a set of capabilities based on our understanding of MITA capabilities in general, specific capabilities in Framework 2.0 were yet to be developed, were lacking in specificity to the process, or were limited in scope. For those processes that had no defined capabilities a brief set of FOX developed capabilities were utilized. These capabilities were developed based on FOX's understanding of the MITA Framework for use where the Business Capability Matrix (BCM) was noted as To Be Developed (TBD). This set of capabilities can be found in section 5.3FOX Defined TBD Capabilities

3.2.1.1 MITA Maturity Levels

The MITA Framework uses the maturity model to define boundaries and provide guidelines for the transformation of the Medicaid Enterprise from the current level of maturity (As-Is Business Process/As-Is Technical Function) to progressively higher levels of performance (To-Be Business Process/To-Be Technical Function). Prior to any discussion of the maturity assessment of business processes for an organization, an understanding of what capabilities are expected at a given maturity level is necessary. The following describes at a high level the capabilities associated with each maturity level.

Level 1
At Level 1, the agency focuses on meeting compliance thresholds dictated by State and Federal regulations. It primarily targets accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.[2]

Level 1 has many manual operations in fragmented programs, and automated MMIS data is used for claims processing and post-payment validation.

Level 2
At Level 2, the agency focuses on cost management and improving quality of and access to care within structures designed to manage costs, e.g., managed care, catastrophic care management, disease management.[2]

Level 2 has a mix of manual, fax, scanning, mainframe, distributed, desktop, and web operations, but still with fragmented programs and limited use of MMIS data outside of claims processing and related functions.

Level 3
At Level 3, the agency focuses on coordination with other agencies and collaboration in adopting national standards and developing shared business services as a means to improving cost-effectiveness of health care service delivery. The agency promotes usage of intra-state data exchange.[2]

In Level 3, the MITA framework supports the Medicaid enterprise as a whole with stakeholders accessing the program over the web and Medicaid data informing most program planning and management decisions.

[2] *From the MITA Framework 2.0, page I.B-14*

Level 4
At Level 4, widespread and secure access to clinical data enables the Medicaid enterprise to improve health care outcomes, empower beneficiary and provider stakeholders, measure quantitative objectives, and focus on program improvement.[2]

Level 4 extends Level 3 capabilities to all health and human services programs whose beneficiaries receive Medicaid, incorporates external clinical data, and has automated data exchange among health and human services programs.

Level 5
At Level 5, national (and international) interoperability allows the Medicaid enterprise to focus on fine-tuning and optimizing program management, planning, and evaluation. [2]

Medicaid through MITA is integrated with the National Health Information System (NHIS) with real-time information sharing among Federal and State agencies and program stakeholders.

3.2.1.2 IME Business Process Maturity Matrix

The following table allows the reader to see, at a glance, the maturity levels assessed for each business process (the darker shaded cell on any one row represents the assessed maturity level). This demonstrates the potential variety of maturity levels for the individual business processes that contribute to the overall maturity level for the entire business area.

Table 10 Business Process As-Is Maturity Matrix

BP#	IME Business Process	Maturity Level 1	Maturity Level 2	Maturity Level 3	Maturity Level 4	Maturity Level 5
Member Management Business Area						
ME01	Determine Eligibility					
ME02	Enroll Member					
ME03	Disenroll Member					
ME04	Inquire Member Eligibility					
ME05	Manage Applicant and Member Communication					
ME06	Manage Member Grievance and Appeal					
ME07	Manage Member Information					
ME08	Perform Population and Member Outreach					
Provider Management Business Area						
PM01	Enroll Provider					
PM02	Disenroll Provider					
PM03	Inquire Provider Information					
PM04	Manage Provider Communication					
PM05	Manage Provider Grievance and Appeal					
PM06	Manage Provider Information					
PM07	Perform Provider Outreach					

BP#	IME Business Process	Maturity Level 1	Maturity Level 2	Maturity Level 3	Maturity Level 4	Maturity Level 5
Contractor Management Business Area						
CO01	Produce Administrative or Health Services Contract					
CO02	Award Administrative or Health Services Contract					
CO03	Manage Administrative or Health Services Contract					
CO04	Close-out Administrative or Health Services Contract					
CO05	Manage Contractor Information					
CO06	Manage Contractor Communication					
CO07	Perform Contractor Outreach					
CO08	Support Contractor Grievance and Appeal					
CO09	Inquire Contractor Information					
Operations Management						
OM01	Authorize Referral					
OM02	Authorize Service					
OM03	Authorize Treatment Plan					
OM04	Apply Claim Attachment					
OM05	Apply Mass Adjustment					
OM06	Edit Claim/Encounter					
OM07	Audit Claim					
OM08	Price Claim/Encounter					
OM09	Prepare Remittance Advice/Encounter Report					
OM10	Prepare Provider EFT/Check					
OM11	Prepare COB/TPL	N/A				
OM12	Prepare EOB					
OM13	Prepare HCBS Payment					
OM14	Prepare Premium EFT/Check					
OM15	Prepare Capitation Premium Payment					
OM16	Prepare Health Insurance Premium Payment					
OM17	Prepare Medicare Premium Payment					
OM18	Inquire Payment Status					
OM19	Manage Payment Information					
OM20	Calculate Spend-down Amount					
OM21	Prepare Member Premium Invoice					
OM22	Manage Drug Rebate					
OM23	Manage Estate Recovery					
OM24	Manage Recoupment					
OM25	Manage Settlement					
OM26	Manage TPL Recovery					
Program Management Business Area						
PG01	Designate Approved Service/Drug List					

BP#	IME Business Process	Maturity Level 1	Maturity Level 2	Maturity Level 3	Maturity Level 4	Maturity Level 5
PG02	Develop and Maintain Benefit Package					
PG03	Manage Rate Setting					
PG04	Develop Agency Goals and Objectives					
PG05	Develop and Maintain Program Policy					
PG06	Maintain State Plan					
PG07	Formulate Budget					
PG08	Manage Federal Financial Participation for MMIS					
PG09	Manage F-MAP					
PG10	Manage State Funds					
PG11	Manage 1099s					
PG12	Generate Financial and Program Analysis Reports					
PG13	Maintain Benefits/Reference Information					
PG14	Manage Program Information					
PG15	Perform Accounting Functions					
PG16	Develop and Manage Performance Measures and Reporting					
PG17	Monitor Performance and Business Activity					
PG18	Draw and Report FFP					
PG19	Manage FFP for Services					
PGIA01	Manage Legislative Communication					
Business Relationship Management Business Area						
BR01	Establish Business Relationship					
BR02	Manage Business Relationship					
BR03	Terminate Business Relationship					
BR04	Manage Business Relationship Communications					
Program Integrity Management Business Area						
PI01	Identify Candidate Case					
PI02	Manage Program Integrity Case					
Care Management Business Area						
CM01	Establish Case					
CM02	Manage Care Management Case					
CM03	Manage Medicaid Population Health					
CM04	Manage Registry	N/A				

3.2.1.3 IME Business Process Descriptions and As-Is Maturity Assessments

This section includes tables for each business process that contain the description of the associated MITA Business Process (BP), the description of IME's process, the assessed As-Is maturity level of the process, and a brief explanation regarding why the process was assessed at the specified level. The tables are grouped by Business Area. The source data for these tables can be found in the Business Process Templates. These templates are currently on the FOX Portal. They will eventually be moved to a project library on the IME network.

3.2.1.3.1 Member Management

Determine Eligibility (ME01)
MITA Business Process 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.
IME Business Process Description
The **Determine Eligibility** business process in Iowa is carried out by the Income Maintenance Workers and Administrators in the local field offices. Automated portions of the process are implemented in the ABC and Title XIX systems. The Process receives an eligibility application data set from the receive inbound transaction process; checks for status (e.g., new, resubmission, duplicate); establishes type of eligible; 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 a request for notification data set that is sent to the Manage Member Communication process (the notification can be in regards to the eligibility determination or a request for more information.) Note: Eligibility determinations requiring medical information are part of the **Enroll Member** business process

Determine Eligibility (ME01)

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not fully at Level 3 because data across platforms does not currently conform to a unified set of data standards; processing is not supported by an automated rules-engine; all verifications are not automated; turn-around time is not yet immediate; and choices among services and provider types available within funding limits of all benefit packages for which the member is eligible is not available to members.

Enroll Member (ME02)

MITA Business Process Description

The **Enroll Member** business process receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible (e.g., managed care, HIPAA, waiver), 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.
See Attachment A for details associated with specific groups of eligibility, i.e., managed care, HIPAA, waiver.
NOTE: There is a separate business process for disenroll member.

IME Business Process Description

The **Enroll Member** business process receives eligibility data from the **Determine Eligibility** process, determines additional qualifications for enrollment in programs for which the member may be eligible (e.g., managed care, waiver), offers a choice of primary care providers for some programs, requests notifications to the member and the contractor be sent via the **Manage Member Communication** and **Manage Contractor Communication** processes, and sends the enrollment outcome data to the **Manage Member Information** process for loading the into the Member Information data store.

Most enrollment steps are automated (via the Title XIX and Isis systems) with those that are manual (i.e. medical screenings) handled by IME Policy or by Income Maintenance or Service Workers in the local field offices.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is somewhat “siloed” (by system and program); data across platforms does not currently conform to a unified set of data standards; responses may be untimely and inconsistent; lack of automated business rules; eligibility and enrollment are completely separate processes (due to time constraints of the systems); not meeting member linguistic needs via provider match; no attention to meeting member cultural needs;

Enroll Member (ME02)

there is no option to submit applications on line; and limited ability to blend benefits to meet member health needs.

Disenroll Member (ME03)

MITA Business Process 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

IME Business Process Description

The **Member Management 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, provider, or contractor
  - Disenrollment based on member's death; failure to meet enrollment criteria, such as a change in health or financial status, or a change of residency outside of service area
  - Request by another Business Area, e.g., **Prepare Member Premium Invoice** process for the failure to pay premiums

Disenroll Member (ME03)

- Program Integrity business area for fraud and abuse
- Mass Disenrollment

- Validation that the termination meets state rules and/or policies
- 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

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is "siloed"; data across platforms does not currently conform to a unified set of data standards.

Inquire Member Eligibility (ME04)

MITA Business Process 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.

IME Business Process Description

The Member Management **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

Inquire Member Eligibility (ME04)

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.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because data across platforms does not currently conform to a unified set of data standards, responses may be untimely, inconsistent, or incorrect; manual processing is not yet the exception. *(Note; from the point of view of the process, which assumes requests coming into the agency from an external source, the process is not siloed. From a practical point of view within the agency, eligibility information is siloed across 4 systems because the information on an individual member is inconsistent across systems and more than one system must be accessed to get the complete picture on an individual))*

Manage Applicant and Member Communication (ME05)

MITA Business Process 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.

IME Business Process Description

The **Manage Applicant and Member Communication** business process is handled by various units throughout IME which can include Member Services, Medical Services, Pharmacy Services, field offices, etc. This process receives requests for information, 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

Manage Applicant and Member Communication (ME05)

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 complaints 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.

NOTE: There is a "no wrong door" policy for members. Any unit may receive communication from members which is then forwarded to the appropriate unit.
The Member Services and Income Maintenance Customer Service call centers are available during normal business hours. Responses are tracked to measure performance.
The Medical Services call center will initiate and respond to member communications regarding pre-authorizations, prior authorizations and specialized managed care programs. Staff will track and monitor communications with workflow management system.
The Pharmacy Services call center will receive questions from members regarding the preferred drug list. These calls are tracked and monitored with the pharmacy help desk application.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is "siloed"; responses may be untimely and inconsistent; and linguistic, cultural, and competency factors are not taken into account when designing communication.
Note: IA state law specifies English as the language and limits the emphasis on incorporating linguistic factors into communications.

Manage Member Grievance and Appeal (ME06)

MITA Business Process 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

Manage Member Grievance and Appeal (ME06)

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.

IME Business Process Description

The **Manage Member Complaint and Appeal** business process handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a complaint. The complaint process is informal and can be handled by any unit in the IME. The appeal process is more formalized and is handled primarily through DHS OPA. A complaint or appeal is received by the **Manage Applicant and Member Communication** process via the Receive Inbound Transaction process. The complaint 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 complaints and appeals it handles; grievance and appeals issues; parties that file or are the target of the complaints and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to complaints 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

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual; data across platforms does not currently conform to a unified set of data standards

Manage Member Information (ME07)

MITA Business Process 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

Manage Member Information (ME07)

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**.

IME Business Process 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 IME "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

Manage Member Information (ME07)

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**.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is "siloed" among systems and units; data across platforms does not currently conform to a unified set of data standards updates are a mix of manual and automated; edits are not consistent between systems; day based eligibility/enrollment is not supported; rule-based validation and data reconciliation has not been implemented.

Perform Population & Member Outreach (ME08)

MITA Business Process 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.

IME Business Process Description

Perform Population & Member Outreach (ME08)

The **Perform Population and Member Outreach** business process is handled by Member Services, DHS Eligibility, Policy Analysis, and Medical Services. This 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.

NOTE:

The Member Services unit will recruit candidates for specialized managed care programs, target cases from data warehouse reporting and referrals, and contact members to explain program advantages and constraints. Letters to members go through Member Services.

The Medical Services unit will perform individualized education and supply educational materials to members, recruit candidates for specialized managed care programs, target cases from data warehouse reporting and referrals, and contact members to explain program advantages and constraints.

DHS Policy Analysis is responsible for handling forms or form letters.

Web site data is not centrally managed.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is "siloed"; linguistic, cultural, and competency factors are not taken into account when designing all outreach, electronic storage of outreach materials is not universal, the web site is not structured to collect data on member usage.

Note: IA state law specifies English as the language and limits the emphasis on incorporating linguistic factors into outreach.

3.2.1.3.2 Provider Management

Enroll Provider (PM01)

MITA Business Process Description

The **Enroll Provider** business process is responsible for managing providers' enrollment including:

1. Receipt of enrollment application data set from the **Manage Provider Communication** process.
2. Processing of applications, including status tracking (e.g., new, resubmission, duplicate) and validating application meets Federal and State submission rules, e.g., syntax/semantic conformance.
3. Validation that the enrollment meets Federal and State rules by
   a. Performing primary source verification of provider credentials and sanction status with external entities, including:
      - Education and training/Board certification
      - License to practice
      - DEA/CDS Certificates
      - Medicare/Medicaid sanctions
      - Disciplinary/sanctions against licensure which may include external States
      - Malpractice claims history
      - NPDB (National Provider Data Bank) and HIPDB (Health Integrity Protection Data Base) disciplinary actions/sanctions
      - Verifying or applying for NPI enumeration with the NPPES
      - Verifying SSN or EIN and other business information
   b. Performing policy requirements for atypical providers such for a nonemergency provider might include validation of transportation insurance, valid driver's license
4. Determination of contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill.
5. Establishment of payment rates and funding sources, taking into consideration service area, incentives or discounts.
6. Negotiation of contracts.
7. Supporting receipt and verification of program contractor's provider enrollment roster information, e.g., from MCO and HCBS organizations.
8. Requesting that the **Manage Provider Information** process load initial and changed enrollment information, including providers contracted with program contractors into the Provider data store.
9. Prompting the **Manage Provider Information** process to provide timely and accurate notification, or to make enrollment data required for operations available to all parties and affiliated business processes, including:
   a. The capitation and premium payment area
   b. The prepare provider EFT/check process
   c. The appropriate communications; outreach and education processes for follow-up with the affected parties, including informing parties of their procedural rights.
10. Performing scheduled user-requested:
    a. Credentialing re-verification.

Enroll Provider (PM01)

b. Sanction monitoring.
c. Payment rate negotiations
d. Performance evaluation.

External contractors such as quality assurance and credentialing verification services may perform some of these steps.

IME Business Process Description

The **Enroll Provider** business process is responsible for managing providers' enrollment including:

1. Receipt of enrollment application data set from the **Manage Provider Communication** process.
2. Processing of applications, including status tracking (e.g., new, resubmission, duplicate) and validating application meets Federal and State submission rules, e.g., syntax/semantic conformance.
3. Validation that the enrollment meets Federal and State rules by
   a. Performing primary source verification of provider credentials and sanction status with external entities, including but not limited to:
      - Education and training/Board certification
      - License to practice
      - DEA/CDS Certificates
      - Medicare/Medicaid sanctions
      - Disciplinary/sanctions against licensure which may include external States
      - NPDB (National Provider Data Bank) and HIPDB (Health Integrity Protection Data Base) disciplinary actions/sanctions
      - Verifying SSN or EIN and other business information
      - State/National accreditation
   b. Performing policy requirements for atypical providers such for a nonemergency provider might include validation of transportation insurance, valid driver's license
4. Determination of contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill.
5. Requesting that the **Manage Provider Information** process load initial and changed enrollment information
6. Prompting the **Manage Provider Information** process to provide timely and accurate notification, or to make enrollment data required for operations available to all parties and affiliated business processes, including:
   a. The capitation and premium payment area
   b. The prepare provider EFT/check process
   c. The appropriate communications; outreach and education processes for follow-up with the affected parties, including informing parties of their procedural rights.
7. Performing scheduled user-requested:
   a. Credentialing re-verification.
   b. Sanction monitoring.

External contractors such as quality assurance and credentialing verification services may perform some of these steps. (HCBS-ISU contract)

Enroll Provider (PM01)

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level 2 because, while some process steps may be automated, a number that are directly addressed in the capabilities are not; data to support this process must be drawn from multiple systems and these systems and related interfaces do not currently conform to a unified set of data standards; and the collection of information that facilitates matching providers to patient needs (e.g., cultural and linguistic factors), provider business relationships, and to support the monitoring and delivery of quality care.

Disenroll Provider (PM02)

MITA Business Process Description

The **Disenroll Provider** business process is responsible for managing providers' enrollment in programs, including:

- Processing of disenrollment
  - Requested by the provider
  - Requested by another Business Area, e.g., the **Manage Provider Communication**, **Monitor Performance and Business Activities**, and Program Integrity **Manage Case** processes
  - Due to receipt of information about a provider's death, retirement, or disability from the **Manage Provider Communication** process
  - Based on failure in the Enroll Provider process, e.g., Provider fails to meet state enrollment requirements
    - Provider fails enumeration or credentialing verification
    - Provider cannot be enumerated through NPPES or state assigned enumerator
    - Lack of applicable rates
    - Inability to negotiate rates or contract
- Tracking of disenrollment requests and records, including assigning identifiers and monitoring status (e.g., new, resubmission, duplicate)
- Validation that the disenrollment meets state rules and substantiating basis for disenrollment, e.g., checking death records
- Requesting that the **Manage Provider Information** process load initial and changed disenrollment information into the Provider Registry
- Prompting the **Manage Provider Communication** process to prepare disenrollment notifications and instructions for closing out provider contracts for generation and transmission by the **Send Outbound Transaction** process
- Prompting the **Manage Provider Information** process to provide timely and accurate notification or to make disenrollment data required for operations available to all parties and affiliated business processes, including
  - The Capitation and Premium Payment Area
  - The Prepare Provider EFT/Check process
- Prompting **Manage Applicant and Member Communication** process to notify and reassign,

Disenroll Provider (PM02)

where necessary, members who are on the provider's patient panel, e.g., PCCM, Lock-in, HCBS and other waiver program, and FFS
- Prompting **Perform Applicant and Member Outreach** to provide appropriate outreach and educational material to displaced members.

IME Business Process Description

The **Disenroll Provider** business process is responsible for managing providers' enrollment in programs, including:
- Processing of disenrollment
  - Requested by the provider
  - Requested by another Business Area, e.g., the **Manage Provider Communication**, **Monitor Performance and Business Activities**, and Program Integrity **Manage Case** processes
  - Due to receipt of information about a provider's death, retirement, or disability from the **Manage Provider Communication** process
  - Based on failure in the Enroll Provider process, e.g., Provider fails to meet state enrollment requirements
    - Provider fails enumeration or credentialing verification
    - Provider cannot be enumerated through NPPES or state assigned enumerator
- Tracking of disenrollment requests and records, including assigning identifiers and monitoring status (e.g., new, resubmission, duplicate)
- Validation that the disenrollment meets state rules and substantiating basis for disenrollment, e.g., checking death records
- Requesting that the **Manage Provider Information** process load initial and changed disenrollment information into the Provider Registry
- Prompting the **Manage Provider Communication** process to prepare disenrollment notifications and instructions for closing out provider contracts for generation and transmission by the Send Outbound Transaction process
- Prompting the **Manage Provider Information** process to provide timely and accurate notification or to make disenrollment data required for operations available to all parties and affiliated business processes, including
  - The Capitation and Premium Payment Area
  - The **Prepare Provider EFT/Check** process
- Prompting **Manage Applicant and Member Communication** process to notify and reassign, where necessary, members who are on the provider's patient panel, e.g., PCCM, Lock-in, HCBS and other waiver program, and FFS
- Prompting **Perform Applicant and Member Outreach** to provide appropriate outreach and educational material to displaced members.

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not fully at level 3 because the process is still a mix of manual and automated processes; coordination with other agencies regarding the exchange of data (common

Disenroll Provider (PM02)

data standards) still needs improvement; and the process has not been implemented as a shared service.

Inquire Provider Information (PM03)

MITA Business Process Description

The **Inquire Provider Information** business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.

IME Business Process Description

The IME **Inquire Provider Information** business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is "siloed" and requestors have many points of entry to the process;

Manage Provider Communication (PM04)

MITA Business Process Description

The **Manage Provider Communication** business process receives requests for information, provider publications, and assistance from prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via Send Outbound Transaction process.
Note: Inquires from prospective and current providers are handled by the **Manage Provider Communication** process by providing assistance and responses to individual entities, i.e., bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The **Perform Provider Outreach** process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues.

IME Business Process Description

Manage Provider Communication (PM04)

The IME **Manage Provider Communication** business process receives requests for information, provider publications, and assistance from prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via Send Outbound Transaction process.

Note: Inquires from prospective and current providers are handled by the **Manage Provider Communication** process by providing assistance and responses to individual entities, i.e., bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The **Perform Provider Outreach** process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual and non-routine responses may be untimely and inconsistent.

Manage Provider Grievance and Appeal (PM05)

MITA Business Process Description

The **Manage Provider Grievance and Appeal** business process handles provider* appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the **Manage Provider Communication** process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process.

This process supports the Program 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, depending on State laws. States may involve multiple agencies in the **Provider Grievance and Appeal** process.

*This process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when an application for enrollment is denied.

IME Business Process Description

Manage Provider Grievance and Appeal (PM05)

The **Manage Provider Complaint, Grievance and Appeal** business process handles provider appeals of adverse decisions or communications of a complaint or grievance. A complaint, grievance or appeal is received by the **Manage Provider Communication** process via the Receive Inbound Transaction process. The complaint, grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; an appeals hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the appeals hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process.

This process supports the Program Management Business Area by providing data about the types of complaints, grievances and appeals it handles; complaint, grievance and appeals issues; parties that file or are the target of the complaint, grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to complaints, grievances and appeals.

NOTE: This process supports complaints, grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a complaint, grievance or appeal, for example, when an application for enrollment is denied.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because parts of the process are "siloed" (complaints and grievances are processed in multiple parts of the agency, appeals are centralized); manual (processing, communication, and storage of case records), data across platforms does not currently conform to a unified set of data standards (to support research), and responses may be untimely and inconsistent.

Manage Provider Information (PM06)

MITA Business Process Description

The **Manage Provider Information** business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the State Medicaid. The Provider data store is the Medicaid enterprise "source of truth" for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The data store includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services. In addition, the Provider data store stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and all communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal. The Provider data store may store records

Manage Provider Information (PM06)

or pointers to records for services requested and services provided; performance, utilization, and program integrity reviews; and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member data store to add, delete, or change this information in data store records. The Provider data store validates data upload requests, applies instructions, and tracks activity. The Provider data store provides access to provider records to applications and users via batch record transfers, responses to queries, and "publish and subscribe" services.

IME Business Process Description

The IME **Manage Provider Information** business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the State Medicaid. The Provider data store is the IME "source of truth" for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The data store includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services. In addition, the Provider data store stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and most communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal. The Provider data store may store records or pointers to records for services requested and services provided; performance, utilization, and program integrity reviews; and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member data store to add, delete, or change this information in data store records. The Provider data store validates data upload requests, applies instructions, and tracks activity. The Provider data store provides access to provider records to applications and users via batch record transfers, responses to queries, and "publish and subscribe" services.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is "siloed" (by system), changes are not immediately available across systems, linguistic and cultural information is not collected on all providers (linguistic information is currently collected only for Managed Care providers).
Note: IA state law specifies English as the language and limits the emphasis on incorporating linguistic factors into data collected on providers.

Perform Provider Outreach (PM07)

MITA Business Process Description

The **Perform Provider Outreach** business process originates internally within the Medicaid

Perform Provider Outreach (PM07)

Enterprise in response to multiple activities, e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, changes in the Medicaid program policies and procedures.

Prospective Provider outreach information, also referred to as Provider Recruiting information, may be developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers)

Enrolled Provider outreach information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives.

Outreach communications and information packages are distributed accordingly through various media. All outreach communications and information package production and distribution are tracked and materials archived according to state archive rules. Outreach efficacy is measured by the **Monitor Performance and Business Activity** process.

IME Business Process Description

The IME **Perform Provider Outreach** business process originates internally within the Medicaid Enterprise in response to multiple activities, e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, changes in the Medicaid program policies and procedures.

Prospective Provider outreach information, also referred to as Provider Recruiting information, may be developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers)

Enrolled Provider outreach information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives.

Outreach communications and information packages are distributed accordingly through various media. All outreach communications and information package production and distribution are tracked and materials archived according to state archive rules. Outreach efficacy is measured by the **Monitor Performance and Business Activity** process.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is “siloed”; and outreach may be untimely when external factors impact the outreach, use of the portal/web site is not monitored therefore IME cannot target providers that are not accessing the information.

Perform Provider Outreach (PM07)
Note: IA state law specifies English as the language and limits the emphasis on incorporating linguistic factors into outreach.

3.2.1.3.3 Contractor Management

Produce Administrative or Health Services RFP (CO01)	
MITA Business Process Description	
The **Produce Administrative or Health Services RFP** business process gathers requirements, develops a Request for Proposals (RFP), requests and receives approvals for the RFP, and solicits responses.	
IME Business Process Description	
The **Produce Administrative or Health Services RFP** business process gathers requirements, develops a Request for Proposals (RFP), requests and receives approvals for the RFP, and solicits responses.	
IME As-Is Maturity Level	Level 1
Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual.	

Award Administrative or Health Service Contract (CO02)
MITA Business Process Description
The **Award an Administrative or Health Services Contract** business process utilizes requirements, advanced planning documents, requests for information, request for proposal and sole source documents. This process is used to request and receive proposals, verifies proposal content against RFP or sole source requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, and notifies parties. In some States, this business process may be used to make a recommendation of award instead of the award itself.
IME Business Process Description
The IME **Award an Administrative or Health Services Contract** business process utilizes requirements, advanced planning documents, requests for information, request for proposal and sole source documents. This process is used to request and receive proposals, verifies proposal content against

Award Administrative or Health Service Contract (CO02)

RFP or sole source requirements, applies evaluation criteria, designates contractor/vendor, posts award information, negotiates contract, and notifies parties. In some States, this business process may be used to make a recommendation of award instead of the award itself.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual.

Manage Administrative or Health Services Contract (CO03)

MITA Business Process Description

The **Manage Administrative or Health Services 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.

IME Business Process Description

The IME **Manage Administrative or Health Services 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.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual.

Close-out Administrative or Health Services Contract (CO04)

MITA Business Process Description

The **Close-out Administrative or 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.

IME Business Process Description

The IME **Close-out Administrative or 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

Close-out Administrative or Health Services Contract (CO04)

obligations.

NOTE: The contract may end with no succession

IME-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual.

Manage Contractor Information (CO05)

MITA Business Process Description

The **Manage Contractor Information** business process receives a request for addition, deletion, or change to the Contractor data store; validates the request, applies the instruction, and tracks the activity.

IME Business Process Description

The **Manage Contractor Information** business process receives a request for addition, deletion, or change to the Contractor data store; validates the request, applies the instruction, and tracks the activity.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because information requests are not standardized and data is siloed among the CAO and the Units so data may not be immediately available.

Manage Contractor Communication (CO06)

MITA Business Process Description

The **Manage Contractor Communication** business process receives requests for information, appointments, and assistance from contractors 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.

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.

Manage Contractor Communication (CO06)

Other examples of communications include:

- Pay for performance communications – performance measures could effect capitation payments or other reimbursements.
- Incentives to improve encounter data quality and submission rates

IME Business Process Description

The **Manage Contractor Communication** business process receives requests for information, appointments, and assistance from contractors 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.

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.

Other examples of communications include:

- Pay for performance communications – performance measures could effect capitation payments or other reimbursements.
- Incentives to improve encounter data quality and submission rates

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not fully at Level 3 because the process is primarily manual and contractor data is siloed among the CAO and the Units.

Perform Contractor Outreach (CO07)

MITA Business Process Description

The **Perform 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, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs.

For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives.

Contractor outreach communications are distributed through various mediums via **Send Outbound**

Perform Contractor Outreach (CO07)

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.

IME Business Process Description

The **Perform 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, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs.

For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives.

Contractor outreach communications are distributed through various mediums via 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.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process does not include TV, radio, or advertisements as mechanisms for targeting prospective contractors and performance measures do not provide clinical and administrative indicators of populations needed to target outreach to contractors to ensure population health and access.

Support Contractor Grievance and Appeal (CO08)

MITA Business Process 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 M**anage 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 Management** business area by providing data about the types of

Support Contractor Grievance and Appeal (CO08)

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.

IME Business Process 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 triaged to appropriate reviewers; researched; additional information may be requested; and a hearing is scheduled and conducted in accordance with administrative and legal requirements. The contractor is formally notified of the decision via the Send Outbound Transaction process.
This process supports the Program Management business area by providing data about the types of grievances and appeals it handles. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.

NOTE: The grievance and appeal process is defined in the contract. In the procurement process, the grievance or appeal goes to the IA District Court.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual

Inquire Contractor Information (CO09)

MITA Business Process 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.

IME Business Process Description

The **Inquire Contractor Information** business process receives requests for contract verification from authorized users, programs or business associates; performs the inquiry; and prepares the response data set for the send outbound transaction process.

IME As-Is Maturity Level	Level 1

Inquire Contractor Information (CO09)
Fully meets Level 1 capabilities. Not fully at Level 2 because the process is primarily manual.

3.2.1.3.4 Operations Management

Authorize Referral (OM01)
MITA Business Process Description
The **Authorize Referral** business process is used when referrals between providers must be approved for payment, based on state policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. This business process is primarily associated with Primary Care Case Management programs where additional approval controls are deemed necessary by the State. Most States do not require this additional layer of control. NOTE: MITA contains three different "Authorize Service" business processes: 1. **Authorize Service** – the standard process of prior authorization of fee-for-service service 2. **Authorize Treatment Plan** – the approval of a treatment plan prepared by a care management team in a care management setting 3. **Authorize Referral** – specifically the approval of a referral to another provider, requested by a primary care physician The Authorize Referral business process may encompass both a pre-approved and post-approved referral request, especially in the case where immediate services are required. This business process may include, but is not limited to, referrals for specific types and numbers of visits, procedures, surgeries, tests, drugs, durable medical equipment, therapies, and institutional days of stay. Requests are evaluated based on urgency and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state, validating key data, and ensuring that the referral is appropriate and medically necessary. ability to perform activities of daily living. • A post-approved referral request is an editing/auditing function that requires review of information after the referral has been made. A review may consist of: verifying documentation to ensure that the referral was appropriate, and medically and or functionally necessary; validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the Edit Claims/Encounter or Audit Claims/Encounter processes.

Authorize Referral (OM01)

IME Business Process Description

The IME **Authorize Referral** business process is used when referrals between providers must be approved for payment, based on state policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. This business process is primarily associated with Primary Care Case Management programs where additional approval controls are deemed necessary by the State. Most States do not require this additional layer of control.

The Authorize Referral business process may encompass both a pre-approved is primarily post-approved referral request, especially in the case where immediate services are required. MediPASS and Lock-in providers and recipients should request referrals prior to treatment. There is an approval process post-treatment.

Requests are evaluated based on urgency and type of service and ensuring that the referral is appropriate and medically necessary. The availability of the provider and service is also considered during the referral process.

- Ability to make the Authorize Referral after the service/treatment occurs.
- Also in **Edit Claims/Encounter** make sure the approval is present on the claim
- Small percentage of audits afterwards to make sure the referral was given.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual.

Authorize Service (OM02)

MITA Business Process Description

The **Authorize Service** business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. It is primarily used in a fee-for-service setting. Pre-approval of a service request is a care management function and begins when a care manager receives a referral request data set from an EDI, Paper/Fax, phone, or 278 Health Care Services Review Inbound Transaction Process. Requests are evaluated based on State rules for prioritization such as urgency and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, out-of-state), validating key data, and ensuring that requested service is appropriate and medically necessary. After review, a service request is approved, modified, denied or pended for additional information. The appropriate response data set for the outbound 278 Response Transaction, 277 Request for additional information or paper/fax notifications/correspondence is sent to the provider using the **Send Outbound Transaction** through **Manage Provider Communication**.

Authorize Service (OM02)

A post-approved service request is an editing/auditing function that requires review of information after the service has been delivered. A review may consist of verifying documentation to ensure that the services were appropriate and medically necessary; validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the **Edit Claims/Encounter** or **Audit Claims/Encounter** processes.

NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs , and Off-label use of drugs, Social Service, Experimental Treatments, Out-of-State Services, and Emergencies.

IME Business Process Description

The IME **Authorize Service** business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. It is primarily used in a fee-for-service setting.

Pre-approval of a service request is a care management function and begins when a care manager receives a referral request data set from a Paper or Fax. Requests are evaluated based on State rules for prioritization such as urgency as identified by the provider, validating key data, and ensuring that requested service is appropriate and medically necessary. After review, a service request is approved, modified, denied or pended for additional information. The appropriate response data set for paper/fax notifications/correspondence is sent to the provider using the Send Outbound Transaction through **Manage Provider Communication** and **Manage Member Communication** (denials only).

A post-approved service request is an editing function that requires review of information after the service has been delivered. A review may consist of verifying documentation to ensure that the services were appropriate to prior authorization; validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the **Edit Claims/Encounter** (claims only) processes.

NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, and Off-label use of drugs.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level two only because, while, EDI is available via HIPAA transaction, this option is not being utilized by providers.

Authorize Treatment Plan (OM03)

MITA Business Process Description

The **Authorize Treatment Plan** business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the

Authorize Treatment Plan (OM03)

Treatment Plan.

A Treatment Plan prior-authorizes the named providers or provider types and services or category of services. Individual providers can be pre-approved for the service or category of services and do not have to submit their own service request. A treatment plan typically covers many services and spans a length of time. (In contrast, an individual service request, primarily associated with fee-for-service payment, is more limited and focuses on a specific visit, services, or products, such as a single specialist office visit referral, approval for a specific test or particular piece of Durable Medical Equipment [DME]).

The pre-approved treatment plan generally begins with the receipt of an authorize treatment plan request from the care management team, is evaluated based on urgency, State priority requirements, and type of service/taxonomy (speech, physical therapy, home health, behavioral, social). It includes validating key data, and ensuring that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, the request is approved, modified, pended, or denied and the appropriate response data set is forwarded to the Care Management team and the **Manage Provider Communication** process.

A post-approved treatment plan is an audit function that reviews pended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.

NOTE: MITA contains three different "Authorize Service" business processes:

- **Authorize Service** – the standard process of prior authorization of fee-for-service service
- **Authorize Treatment Plan** – the approval of a treatment plan prepared by a care management team in a care management setting
- **Authorize Referral** – specifically the approval of a referral to another provider, requested by a primary care physician

IME Business Process Description

The IME **Authorize Treatment Plan** business process encompasses both a pre-approved and post-approved treatment plan. The **Authorize Treatment Plan** is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan.

A Treatment Plan prior-authorizes the named providers or provider types and services or category of services. Individual providers can be pre-approved for the service or category of services and do not have to submit their own service request. A treatment plan typically covers many services and spans a length of time. (In contrast, an individual service request, primarily associated with fee-for-service payment, is more limited and focuses on a specific visit, services, or products, such as a single specialist office visit referral, approval for a specific test or particular piece of Durable Medical Equipment [DME]).

For remedial services the pre-approved treatment plan generally begins with the receipt of an

Authorize Treatment Plan (OM03)

authorize treatment plan request from the care management team, program waiting lists, and type of service (speech, physical therapy, home health, behavioral, social). It includes validating key data, and ensuring that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, the request is approved, modified, pended, or denied and the appropriate response data set is forwarded to the Care Management team and the **Manage Provider Communication** process and **Manage Applicant and Member Communication** process

HCBS and habilitation services are established by case managers and then go through a workflow approval process. Results in treatment plan being approved/denied/modified and the appropriate response data set is forwarded to the Care Management team and the **Manage Provider Communication** process and **Manage Applicant and Member Communication** process.

A post-approved treatment plan is a random quality review to ensure the reviewed services were appropriate and in accordance with the treatment plan.

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not fully at level 3 because the process is not a service and national standards have not yet been implemented (MITA standards have not yet been defined). *Note, while not mentioned in the level 2 or 3 capabilities, the centralization of this process is likely to be a capability at level 3 in the future. Responsibility for the process is distributed between providers, IME contractors, and DHS Case Managers. MITA's goal is to encourage standardization of all common processes (i.e. eliminating siloes), or common parts of a process (in the case of distributed but not duplicative responsibility).*

Apply Claim Attachment (OM04)

MITA Business Process Description

This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) or has been sent by the provider (unsolicited).The solicited attachment data sets can be in response to requests for more information from the following processes for example: **Audit Claim/Encounter, Authorize Service, Authorize Treatment Plan, and Manage Estate Recovery**. The attachment data set is then linked to the associated applicable transaction [claim, prior authorization, treatment plan, etc.] and is either attached to the associated transaction or pended for a predetermined time period set by state-specific business rules, after which it is purged. Next, the successfully associated attachment data set is validated using application level edits, determining whether the data set provides the additional information necessary to adjudicate/approve the transaction. If yes, the attachment data set is moved with the transaction to the approval process. If no, it is moved to a denial process or triggers an appropriate request for additional information, unless precluded by standard transaction rules.

Apply Claim Attachment (OM04)

IME Business Process Description

This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) or has been sent by the provider (unsolicited). The solicited attachment data sets can be in response to requests for more information from the following processes for example: **Audit Claim/Encounter, Authorize Service, and Authorize Treatment Plan.**

The attachment data set is then linked to the associated applicable transaction [claim, prior authorization, treatment plan, etc.] and is either attached to the associated transaction or pended for a predetermined time period set by state-specific business rules, after which it is purged. Next, the successfully associated attachment data set is validated using application level edits, determining whether the data set provides the additional information necessary to adjudicate/approve the transaction. If yes, the attachment data set is moved with the transaction to the approval process. If no, it is moved to a denial process or triggers an appropriate request for additional information, unless precluded by standard transaction rules.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level 2 because the process is manual.

Apply Mass Adjustment (OM05)

MITA Business Process Description

The **Apply Mass Adjustment** business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the payment transactions such as claims or capitation payment records by identifiers including, but not limited to, claim/bill type, HCPCS, CPT, Revenue Code(s), or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that may reverse or amend the paid transaction and repay correctly.

NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment may involve many previous payments based on a specific date or date range affecting single or multiple providers, members, or other payees. Likewise, Mass Adjustment historically refers to large scale changes in payments as opposed to disenrolling a group of members from an MCO.

IME Business Process Description

The **Apply Mass Adjustment** business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the payment transactions such as claims or capitation payment records

Apply Mass Adjustment (OM05)

by identifiers including, but not limited to, rates, provider type, claim/bill type, HCPCS, CPT, Revenue Code(s), NPI, or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that may reverse or amend the paid transaction and repay correctly.

NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment may involve many previous payments based on a specific date or date range affecting single or multiple providers, members, or other payees. Likewise, Mass Adjustment historically refers to large scale changes in payments as opposed to disenrolling a group of members from an LSO.

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not fully at level 3 because the process is not a service, national standards have not yet been implemented (MITA standards have not yet been defined), and improvements in the flexibility to easily change the criteria for identifying claims and applying the adjustment.

Edit Claims/Encounters (OM06)

MITA Business Process Description

The **Edit Claim/Encounter** business process receives an original or an adjustment claim/encounter data set from the **Receive Inbound Transaction** process and

- Determines its submission status
- Validates edits, service coverage, TPL, coding
- Populates the data set with pricing information

Sends validated data sets to **Audit Claim/Encounter** process and data sets that fail audit to the **Prepare Remittance Advice/Encounter Report** process

All claim/encounter types must go through most of the steps within the **Edit Claim/Encounter** process with some variance of business rules and data. See Constraints.

NOTE: This business process is part of a suite that includes: **Edit Claim/Encounter**, **Audit Claim/Encounter**, **Price Claim/Value Encounter**, **Apply Claim Attachment**, and **Prepare Remittance Advice/Encounter** processes.

NOTE: The **Edit Claim/Encounter** process does not apply to:

- Point of Sale, which requires that Edit, Audit, and other processes be integrated, or
- Direct Data Entry, On-line adjudication, or Web-enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data.

IME Business Process Description

The **Edit Claim/Encounter** business process receives an original or an adjustment claim/encounter

Edit Claims/Encounters (OM06)

data set from the Receive Inbound Transaction process and

- Determines its submission status
- Validates edits, service coverage (claims only), TPL (claims only), coding
- Populates the data set with pricing information (claims only)

Sends validated data sets to the **Audit Claim** (claims) and **Price Claim/Value Encounter** (encounters) processes and data sets that fail audit to the **Prepare Remittance Advice/Encounter Report** process

All claim/encounter types must go through most of the steps within the **Edit Claim/Encounter** process with some variance of business rules and data. See Constraints.

NOTE: This business process is part of a suite. Claims flow through the: **Edit Claim/Encounter**, **Audit Claim**, **Price Claim/Value Encounter**, **Apply Claim Attachment**, and **Prepare Remittance Advice/Encounter Report** processes. Encounters flow through a subset of the above suite: **Edit Claim/Encounter, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter Report**

NOTE: The **Edit Claim/Encounter** and **Audit Claim** processes are very closely related at IME and, in some cases, can happen simultaneously. The Audit process can be considered as a secondary edit.

NOTE: Waivers are received as paper claims (TMC - converted to HCFA 1500) or electronically (837). They go through the standard claims adjudication process. Non-emergency medical transportation claims are processed by the IABC system – data never enters IME. Funding is an administrative cost of Medicaid.

IME As-Is Maturity Level	Level 1

Fully at level 1. Not fully at level 2 because the X12N 277 transaction is not being utilized to request additional information.

Audit Claim (OM07)

MITA Business Process Description

The **Audit Claim-Encounter** business process receives a validated original or adjustment claim/encounter data set from the **Edit Claim-Encounter** process and checks payment history for duplicate processed claims/encounters and life time or other limits.

Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity. Suspends data sets that fail audits for internal review, corrections, or additional information

Sends successfully audited data sets to the **Price Claim-Value Encounter** process

All claim/encounter types must go through most of the steps within the **Audit Claim-Encounter** process with some variance of business rules and data. See Constraints.

NOTE: This process is part of a suite that includes: **Edit Claim-Encounter**, **Audit Claim-Encounter**, **Price Claim-Value Encounter**, **Apply Attachment**, and **Prepare Remittance Advice/Encounter** processes. In **Edit Claim-Encounter**, a single transaction is edited for

Audit Claim (OM07)

valid identifiers and codes, dates, and other information required for the transaction. **Audit Claim-Encounter** is the next step in which a claim-encounter with valid content is further edited against historical data. Edit and Audit could be combined into a single process, e.g., point-of-sale transaction processing.

IME Business Process Description

The **Audit Claim** business process receives a validated original or adjustment claim/encounter data set from the **Edit Claim-Encounter** process and checks payment history for duplicate processed claims/encounters and lifetime or other limits.
Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity. Suspends data sets that fail audits for internal review, corrections, or additional information
Sends successfully audited data sets to the **Price Claim** or **Prepare Remittance Advice/Encounter Report** process
All claim/encounter types must go through most of the steps within the **Audit Claim** process with some variance of business rules and data. See Constraints.

Note: The **Edit Claim/Encounter** and **Audit Claim** processes are very closely related at IME and, in some cases, can happen simultaneously. The Audit process can be considered as a secondary edit.

IME As-Is Maturity Level	Level 1

Fully at level 1. Not fully at level 2 because the X12N 277 transaction is not being utilized to request additional information.

Price Claim/Value Encounter (OM08)

MITA Business Process Description

NOTE: Framework 2.0 describes three separate processes to edit the content of individual claims and encounters, further adjudicate these services against rules and history, and finally price or evaluate the service. These three processes may be combined into a single process. This is an implementation decision. Whether combined or separate, the requirements of Pricing a claim or Evaluating an Encounter are described below.

The **Price Claim-Value Encounter** business process begins with receipt of claim/encounter adjudicated data. Pricing algorithms are applied. Examples include calculating managed care and Primary Care Case Management [PCCM] premiums, calculating and applying member contributions, DRG and/or APC pricing, provider advances, liens and recoupment. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Information data store by passing the appropriate data set to the **Manage Payment Information** process.

Price Claim/Value Encounter (OM08)

All claim types must go through most of the process steps but with different logic associated with the different claim types.

NOTE: An adjustment to a claim is on an exception use case to this process that follows the same process path except it requires a link to the previously-submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the payment history data store.

IME Business Process Description

The **Price Claim-Value Encounter** business process begins with receipt of claim/encounter adjudicated data. Pricing algorithms are applied. Examples include calculating managed care and Primary Care Case Management [PCCM] premiums, calculating and applying member contributions, DRG and/or APC pricing, provider advances, liens and recoupment. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Information data store by passing the appropriate data set to the **Manage Payment Information** process.

All claim types must go through most of the process steps but with different logic associated with the different claim types.

NOTE: An adjustment to a claim is on an exception use case to this process that follows the same process path except it requires a link to the previously-submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the payment history data store.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level 2 because single claim adjustments.

Prepare Remittance Advice/Encounter Report (OM09)

MITA Business Process 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 to reconcile their accounts receivable. This process begins with receipt of data resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data, which is sent to the Send Outbound Transaction technical process for generation into an outbound transaction. The resulting data set is also sent to **Manage Payment Information** to update the Payment Information data store.
NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.

Prepare Remittance Advice/Encounter Report (OM09)

IME Business Process Description

The IME **Prepare Remittance Advice-Encounter Report** business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers to reconcile their accounts receivable. This process begins with receipt of data resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data, which is sent to the Send Outbound Transaction technical process for generation into an outbound transaction. The resulting data set is also sent to **Manage Payment Information** to update the Payment Information data store.

NOTE: This process includes HCBS Payments. See Prepare Home and Community Based Services Payment process for details on the capabilities associated with that process**.**

NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities. Not fully at level 3 because paper RAs are still produced on a regular basis and some, but not all, electronic billers receive electronic RAs.

Prepare Provider EFT/Check (OM10)

MITA Business Process Description

The **Prepare Provider EFT/Check** business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including:

- Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, HCBS provider claims, and MCO encounters based on inputs such as the priced claim, including any TPL, crossover or member payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and taxes, performance incentives, recoupments, garnishments, and liens per data in the Provider data store, Agency Accounting and Budget Area rules, including the **Manage 1099** process
- Payroll processing, e.g., for HCBS providers, includes withholding payments for payroll, federal and state taxes, as well as union dues
- Dispersement of payment from appropriate funding sources per State and Agency Accounting and Budget Area rules
- Associating the EFT with an X12 835 electronic remittance advice transaction is required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities.]
- Routing the payment per the Provider data store payment instructions for electronic fund transfer

Prepare Provider EFT/Check (OM10)

(EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction

- Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history
- Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate, e.g., Pharmacy POS

IME Business Process Description

The IME **Prepare Provider EFT/Check** business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including:

- Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, and HCBS provider claims based on inputs such as the priced claim, including any TPL, crossover or client participation payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and performance incentives, recoupments, garnishments, and liens per data in the Provider data store, Agency Accounting and Budget Area rules, including the **Manage 1099** process
- Disbursement of payment from appropriate funding sources per State and Agency Accounting and Budget Area rules
- Associating the EFT with an X12 835 electronic remittance advice transaction is required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities.]Paper claims have an option to receive an EFT or a paper check.
- Routing the payment per the Provider data store payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to Fiscal Management for actual payment transaction
- Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history
- Support frequency of payments

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities.

Prepare COB (OM11)

MITA Business Process Description

Prepare COB (OM11)

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. The **Prepare COB** business process begins with the completion of the **Price Claim/Value Encounter** process. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria such as error codes and associated disposition, service codes, program codes, third party liability information available from both the original claim and/or eligibility files. This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, formatting of claims data into the outbound EDI data set, validating that the outbound EDI transaction is in the correct format and forwarding to the **Send Outbound Transaction**.

IME Business Process Description

Note: Currently, cost avoidance is conducted by rejecting claims that should first go to a third party. This process is not currently part of IME's operations. The description and steps noted below that relate to processing claims take place in the **Edit Claim/Encounter** or **Audit Claim** processes. Steps noted as TPL activities are part of the **Manage TPL Recovery Process**

The **Prepare COB/TPL** 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. The **Prepare COB/TPL** business process begins with the completion of the **Price Claim/Value Encounter** process. Full (paid/denied) claims file is provided at month end and moved to a COB/TPL file for coordination of benefit related activities based on predefined criteria such as error codes and associated disposition, service codes, program codes, third party liability information available from both the original claim and eligibility files (indicator for Medicare coverage). This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, formatting of claims data into the outbound EDI data set or paper form, validating that the outbound EDI transaction or paper form is in the correct format and forwarding to the Send Outbound Transaction.

Note: Receipt of COB from other payers is part of standard claims processing. For IME this includes receipt of a file from the Medicare FI (Wisconsin's Physicians Group) via a clearinghouse (837) and receipt of Part C claims (837) from Coventry (Medicare's Part C carrier)

IME As-Is Maturity Level	N/A

IME does not currently perform this process

Prepare EOB (OM12)

Prepare EOB (OM12)

MITA Business Process Description

The **Prepare EOB** business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs or letters must be provided to the clients within 45 days of payment of claims.
This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the Explanation of Benefits (EOBs) and/or notification letters, formatting the data into the required data set, which is sent to the **Send Outbound Transaction** for generation. The resulting data set is also sent to **Manage Applicant and Member Communication**.
NOTE: This process does not include the handling of returned data nor does it include sending the EOB Sample Data Set.

IME Business Process Description

The **Prepare EOB** business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs must be provided to the clients within 45 days of payment of claims.
This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the Explanation of Benefits (EOBs) formatting the data into the required data set, which is sent to the Send Outbound Transaction for generation. The resulting data set is also sent to **Manage Applicant and Member Communication**.

IME As-Is Maturity Level	Level 1

Fully at level 1. Not fully at level 2 because the algorithm used to select members who will receive the EOMB is not a true random sample, the sampling process does not yet target selected populations and cultural and linguistic adaptations have not been introduced.

Prepare Home and Community Based Services Payment (OM13)

MITA Business Process Description

Many home and community based services are not part of the traditional Medicaid benefit package. Services tend to be client specific and often are arranged through a plan of care.
Services for Home & Community Based waivers are often rendered by a-typical providers and may or may not be authorized or adjudicated in the same manner as other health care providers.
The **Prepare Home and Community-Based Services Payment** business process describes the preparation of the payment report data set. These will be sent on paper or electronically to providers and used to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the edit, audit, and pricing processes, performing required manipulation

Prepare Home and Community Based Services Payment (OM13)

according to business rules and formatting the results into the required output data set, which is sent to the **Send Outbound Transaction** process for generation into an outbound transaction. The resulting data set is also sent to **Manage Payment History** process for loading into the Payment History Repository. The reimbursement amount is sent to the **Manage Provider Information** process for loading into the Provider Registry for purposes of accounting and taxes.

NOTE: This process does not include sending the home & community based provider payment data set transaction.

IME Business Process Description

IME makes no distinction between HCBS payment report data sets and the production of RAs for medical claims. See the Prepare Remittance Advice process. If, as is noted in the To-Be for HCBS payments, the claims process is simplified for HCBS provider and the result is a payment report that is not an RA, then this process would come into play.

The processes have been documented separately in order to address the differing capability statements.

The IME **Prepare Home and Community-Based Services Payment** business process describes the preparation of the payment report data set. These will be sent on paper or electronically to providers and used to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to **Manage Payment Information** process for loading into the Payment Information data store.

NOTE: Process is handled from the payment side in the same manner as payments for other services requiring prior authorization. This is a once/month billing process.

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities.

Prepare Premium EFT/Check (OM14)

MITA Business Process Description

The **Prepare Premium Capitation EFT/Check** business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including:

- Calculation of:

Prepare Premium EFT/Check (OM14)

- HIPP premium based on members' premium payment data in the Contractor data store
- Medicare premium based on dual eligible members' Medicare premium payment data in the Member data store
- PCCM management fee based on PCCM contract data re: different reimbursement arrangements in the Contractor data store
- MCO premium payments based on MCO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package in the Contractor data store
- Stop-loss claims payments for MCOs in the Contractor data store
- HIFA waiver small employer refunds (i.e. Parents of kids on SCHIP).

- Application of automated or user defined adjustments based on contract, e.g., adjustments or performance incentives
- Dispersement of premium, PCCM fee, or stop loss payment from appropriate funding sources per Agency Accounting and Budget Area rules
- Associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the Premium Payment within the banking system may not be HIPAA covered entities]
- Routing the payment per the Contractor data store payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction
- Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid premium, fees, and stop loss claims transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history

Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate.

IME Business Process Description

The IME **Prepare Premium Capitation EFT/Check** business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including:

- Calculation of:
  - HIPP premium based on members' premium payment data in the Contractor data store
  - Medicare premium based on dual eligible members' Medicare premium payment data in the Member data store
  - PCCM management fee based on PCCM contract data re: different reimbursement arrangements in the Contractor data store
  - LSO premium payments based on LSO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid LSO and benefit package in the Contractor data store
- Application of automated or user defined adjustments based on contract, e.g., adjustments or performance incentives

Prepare Premium EFT/Check (OM14)

- Disbursement of premium, capitation or PCCM fee from appropriate funding sources per Agency Accounting and Budget Area rules
- Associate the LSO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the Premium Payment within the banking system may not be HIPAA covered entities]
- Routing the payment per the Contractor data store payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a Fiscal Management for actual payment transaction
- Updates the **Perform Accounting Function** and/or Financial Management business processes with pending and paid premium, and fees transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history
- Support frequency of payments

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities.

Prepare Capitation Premium Payment (OM15)

MITA Business Process Description

The **Prepare Capitation Premium Payment** business process includes premiums for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the **Member data store**, retrieving the rate data associated with the plan from the **Provider or Contractor data store**, formatting the payment data into the required data set, which is sent to the **Send Outbound Transaction** for generation into an outbound transaction. The resulting data set is also sent to **Manage Payment History** for loading

NOTE: This process does not include sending the capitation payment data set.

IME Business Process Description

The **Prepare Capitation Premium Payment** business process is handled by CORE and IME Policy. This process includes premiums for Managed Care Organizations (MCO) such a Primary Care Case Managers (PCCM), Limited Service Organization (LSO), and other capitated programs such as PACE. This process begins with a timetable for sending data stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the Member data store, retrieving the rate data associated with the plan from the Provider or Contractor data store, formatting the payment data into the required data set, which is sent to the Send Outbound Transaction. The

Prepare Capitation Premium Payment (OM15)

resulting data set is also sent to **Manage Payment History** for loading

NOTE: This process **does not** include sending the capitation payment.

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities.

Prepare Health Insurance Premium Payment (OM16)

MITA Business Process Description

Medicaid agencies are required to pay the private health insurance premiums for members who may have private health insurance benefits through their employers and because of devastating illness are no longer employable and become Medicaid eligible. It can also include children who are Medicaid eligible but also have private health insurance provided by a parent(s). In these circumstances, a cost effective determination is made and a premium is prepared and sent to the member's private health insurance company rather than enrolling them into a Medicaid managed health care plan or pay fee for service claims as submitted by providers.

The **Process Health Insurance Premium Payments** business process begins by receiving eligibility information via referrals from Home and Community Services Offices, schools, community services organizations, or phone calls directly from members; checking for internal eligibility status as well as eligibility with other payers, editing required fields, producing a report, and notifying members. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. The formatted premium payment data set is sent to the **Send Outbound Transaction** for generation into an outbound transaction.

The resulting data set is also sent to **Manage Payment History** for loading and **Maintain Member Information** for updating.

NOTE: This process does not include sending the health insurance premium payment data set.

IME Business Process Description

Medicaid agencies are required to pay the employer/individual health insurance premiums for any Medicaid eligible member in the household who may be covered by the health insurance plan if it is determined cost effective. In these circumstances, a cost effective determination is made and a premium is prepared and sent to the policy holder, employer, or health insurance company. Medicaid becomes the second payer.

The **Prepare Health Insurance Premium Payments** business process begins by screening as part of our standard Medicaid application process. The member's HIPP status is communicated to the policy holder regarding payment/eligibility status. The health insurance premiums are created with a timetable for scheduled payments. The formatted premium payment data set is sent to the Send

Prepare Health Insurance Premium Payment (OM16)

Outbound Transaction and **Prepare Premium Capitation EFT Check**.

The resulting data set is also sent to **Manage Payment Information** for loading and **Manage Member Information** for updating.

DHS Eligibility Policy – is entirely responsible for this process. The related transactions take place entirely outside of IME systems and processes, other than the sharing of TPL data.

IME As-Is Maturity Level	Level 1

Fully at level 1. Not fully at level 2 because payments continue to be made manually.

Prepare Medicare Premium Payment (OM17)

MITA Business Process Description

State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance.
The **Prepare Medicare Premium Payments** business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the **Send Outbound Transaction**. The resulting data set is also sent to **Manage Payment History** and **Manage Member Information** for loading.
NOTE: This process does not include sending the Medicare premium payments EDI transaction.

IME Business Process Description

State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance.

The IME **Prepare Medicare Premium Payments** business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS

Prepare Medicare Premium Payment (OM17)

for verification, formatting the premium payment data into the required output data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to **Manage Payment History** and **Manage Member Information** for loading.

NOTE: This process does not include sending the Medicare premium payments EDI transaction.

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities

Inquire Payment Status (OM18)

MITA Business Process Description

The **Inquire Payment Status** business process begins with receiving a 276 Claim Status Inquiry transaction or a request for information received through other means such as paper, phone, fax or AVR request for the current status of a specified claim(s), calling the payment history data store and/or data store, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response or other mechanism for responding via the medium used to communicate the inquiry, and sending claim status response data set via the **Send Outbound Transaction** process.

IME Business Process Description

The IME **Inquire Payment Status** business process begins with receiving a 276 Claim Status Inquiry transaction or a request for information received through other means such as paper, phone, fax, web portal, email, in person or AVR request for the current status of a specified claim(s), accessing the Payment Information data store, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response or other mechanism for responding via the medium used to communicate the inquiry, and sending claim status response data set via the Send Outbound Transaction process.

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities. Not fully at level 3 because the process is still partially manual for both the provider and the agency; the information is not available 24x7; there are time lags due to cycle schedules and disconnects between the various financial systems (e.g., manual check posting does not carry over to the Payment Information data store); and the X12N 276/277 transactions are not being used by providers, although the agency is currently capable of receiving and sending these transactions.

Manage Payment Information (OM19)

MITA Business Process Description

The **Manage Payment Information** business process is responsible for managing all the operational aspects of the Payment Information data store, which is the source of comprehensive information about payments made to and by the state Medicaid enterprise for health care services.
The Payment Information data store exchanges data with Operations Management business processes that generate payment information at various points in their workflows. These processes send requests to the Payment Information data store to add, delete, or change data in payment records. The Payment Information data store validates data upload requests, applies instructions, and tracks activity.
In addition to Operations Management business processes, the Payment Information data store provides access to payment records to other Business Area applications and users, such as the Program, Member, Contractor, and Provider Management business areas, via record transfers, response to queries, and "publish and subscribe" services.

IME Business Process Description

The IME **Manage Payment Information** business process is responsible for managing all the operational aspects of the Payment Information data store, which is the source of comprehensive information about payments made to and by the state Medicaid enterprise for health care services. This includes claims, encounters, AR, and capitation/premium payments.

The Payment Information data store exchanges data with Operations Management business processes that generate payment information at various points in their workflows. These processes send requests to the Payment Information data store to add, delete, or change data in payment records. The Payment Information data store validates data upload requests, applies instructions, and tracks activity.

In addition to Operations Management business processes, the Payment Information data store provides access to payment records to other Business Area applications and users, such as the Program, Member, Contractor, and Provider Management business areas, via record transfers, response to queries, and "publish and subscribe" services.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level 2 because neither the process nor the data is centralized; data is not fully comparable across platforms; and analysis tools are not available for use against the Payment Information data store. Analysis tools are available on the Data Warehouse but not all payment information is uploaded to the Data Warehouse

Calculate Spend-down Amount (OM20)

MITA Business Process Description

A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called "spend-down" (see Determine Eligibility).
The **Calculate Spend-Down Amount** business process describes the process by which spend-down amounts are tracked and a client's responsibility is met through the submission of medical claims. Excess resources are automatically accounted for during the claims processing process resulting in a change of eligibility status once spenddown has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations.
The **Calculate Spend-Down Amount** business process begins with the receipt of member eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services.
NOTE: The 'Calculate Spend-down Amount' today is primarily a manual process in the Eligibility Determination, Member Payment Management and Maintain Payment History threads. At Level 3 these processes have almost eliminated any use of manual intervention.

IME Business Process Description

A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called "spend-down" (see Determine Eligibility).
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. Medical claims are automatically accounted for during the claims processing processes resulting in a change of eligibility status once spenddown has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels or income limits, but may also occur in other situations.
The eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services. The **Calculate Spend-Down Amount** business process begins with the receipt of member eligibility data.
NOTE: The Eligibility Determination process is primarily a manual process. The **Calculate Spend-Down Amount** process is handled by the MMIS system.

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities. Not fully at level 3 because members are still required to report their costs and the process does not utilize a deductible as a spend-down mechanism.

Prepare Member Premium Invoice (OM21)

MITA Business Process Description

Due to tightening budgets and an ever-increasing population that is covered under the Medicaid umbrella, States began client/member cost-sharing through the collection of premiums for medical coverage. The premium amounts are based on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment.
The **Prepare Member Premium Invoice** business process begins with a timetable (usually monthly) for scheduled invoicing. The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the **Send Outbound Transaction** process for generation into an outbound transaction. The resulting data set is also sent to **Maintain Member Information** process for updating.
NOTE: This process does not include sending the member premium invoice EDI transaction.

IME Business Process Description

The IME **Prepare Member Premium Invoice** business process begins with a timetable for scheduled and unscheduled invoicing (billing statements). The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the Send Outbound Transaction. The resulting data set is also sent to **Manage Member Information** process for updating.
NOTE: This process does not include sending the member premium invoice EDI transaction.

NOTE: This process is limited to IowaCare and MEPD

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level 2 because hearing rights are not part of member premium notifications.

Manage Drug Rebate (OM22)

MITA Business Process 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 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

Manage Drug Rebate (OM22)

code, sending the invoice data to the drug manufacturer via the **Send Outbound Transaction** Process sending to **Perform Accounting Functions**.

IME Business Process 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 comparing it to quarterly payment history data, utilizing drug data based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer via the Send Outbound Transaction Process sending to **Perform Accounting Functions**.

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities

Manage Estate Recovery (OM23)

MITA Business Process Description

Estate recovery is a process whereby States are required to recover certain Medicaid benefits correctly paid on behalf of an individual. This is done by the filing of liens against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, ICF/MR, or other medical institution.

The **Manage Estate Recovery** business process begins by receiving estate recovery data from multiple sources (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), generating correspondence data set (e.g., demand of notice to probate court via **Send Outbound Transaction** process, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the **Manage Applicant and Member Communication** process, opening formal estate recovery case based on estate ownership and value of property, determining value of estate lien, files petition for lien, files estate claim of lien, conducts case follow-up, sending data set to **Perform Accounting Functions**, releasing the estate lien when recovery is completed, updating Member data store, and sending to **Manage Payment History** for loading.

NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.

IME Business Process Description

The IME **Manage Estate Recovery** business process begins by receiving estate recovery data from

Manage Estate Recovery (OM23)

multiple referrals (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), opening estate recovery case based member's death and state criteria, determining value of estate claim, generating correspondence data set (e.g., demand of notice to probate court via Send Outbound Transaction process, to member's personal representative or generating a request letter and questionnaire) via the **Manage Applicant and Member Communication** process, conducts case follow-up, sending data set to track attempted recoveries vs. actual recoveries to Perform Accounting Functions (accounts receivable), releasing the estate claim when recovery is completed, updating Member data store, and sending to **Manage Payment Information** for loading.

NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level 2 because the process is manual.

Manage Recoupment (OM24)

MITA Business Process Description

The **Manage Recoupment** business process describes the process of managing provider recoupment. Provider recoupment are initiated by the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where monies are owed to the agency due to fraud/abuse.

The business thread begins with discovering the overpayment, retrieving claims payment data via the **Manage Claims History**, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results via the **Manage Provider Communication**, applying recoupments in the system via the **Perform Accounting Functions**, and monitoring payment history until the repayment is satisfied.

Recoupments can be collected via check sent by the provider or credited against future payments for services.

IME Business Process Description

The **Manage Recoupment** business process describes the process of managing provider recoupment. Provider recoupments are initiated by the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where

Manage Recoupment (OM24)

monies are owed to the agency due to fraud/abuse.

The business thread begins with discovering the overpayment, retrieving claims payment data via the Manage Claims Information, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results via the **Manage Provider Communication**, applying recoupments in the system via the **Perform Accounting Functions**, and monitoring payment history until the repayment is satisfied.

Recoupments can be collected via payment instrument sent by the provider or credited against future payments for services.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level 2 because the process is primarily manual and mail-based.

Manage Cost Settlement (OM25)

MITA Business Process Description

The **Manage Cost Settlement** business process begins with requesting annual claims summary data from **Manage Payment History**. The process includes reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates. In some States, cost settlements may be made through the application of Mass Adjustments.

IME Business Process Description

The **Manage Cost Settlement** business process begins with requesting annual claims summary data from **Manage Payment Information**. The process includes reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates. In some States, cost settlements may be made through the application of Mass Adjustments.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because communication with providers is mail-

Manage Cost Settlement (OM25)
based.

Manage TPL Recovery (OM26)
MITA Business Process Description
The **Manage TPL Recoveries** business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, attorneys, Program Integrity/Fraud & Abuse, Medicaid Fraud Control Unit, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from **Manage Payment History**, creating post-payment recovery files, sending notification data to other payer or provider from the **Manage Provider Communication** process, receiving payment from provider or third party payer, sending receivable data to **Perform Accounting Function**, and updating payment history **Manage Payment History**. **NOTE:** States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase method.
IME Business Process Description
The IME **Manage TPL Recoveries** business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, attorneys, Program Integrity/Fraud & Abuse, Medicaid Fraud Control Unit, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from **Manage Payment History**, creating post-payment recovery files, sending notification data to other payer or provider from the **Manage Provider Communication** process, receiving payment from provider or third party payer, sending receivable data to **Perform Accounting Function**, and updating payment history **Manage Payment History**.

IME As-Is Maturity Level	Level 2

Fully meets level 2 capabilities.

3.2.1.3.5 Program Management

Designate Approved Service/Drug List (PG01)
MITA Business Process Description
The **Designate Approved Services and Drug Formulary** business process begins with a review of

Designate Approved Service/Drug List (PG01)

new and/or modified service codes (such as HCPCS and ICD-9) or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package.

Service, supply, and drug codes are reviewed by an internal or external team(s) of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and or State plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.

NOTE: This does not include implementation of Approved Services and Drug Formulary.

IME Business Process Description

The **Designate Approved Services and Drug List** business process begins with a review of new and/or modified service codes (such as HCPCS and ICD-9) or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package.

Service, supply, and drug codes are reviewed by an internal or external team(s) of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and or State plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.

NOTE: This does not include implementation of the Approved Services and Drug List codes.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at level 2 because the manual nature of the process and the existence of separately managed processes for service codes and drug codes.

Develop and Maintain Benefit Package (PG02)

MITA Business Process Description

The **Develop & Maintain Benefit Package** business process begins with receipt of coverage requirements and recommendations through new or revised: Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations or changes resulting from court decisions.

Benefit package requirements are mandated through regulations or other legal channels and must be

Develop and Maintain Benefit Package (PG02)

implemented. Implementation of benefit package recommendations is optional and these requests must be approved, denied or modified.
Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including:

- Determination of scope of coverage
- Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc.
- Identification of impacted members and trading partners.

IME Business Process Description

The **Develop & Maintain Benefit Package** business process begins with receipt of coverage requirements and recommendations through new or revised: Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations or changes resulting from court decisions.
Benefit package requirements are mandated through regulations or other legal channels and must be implemented. Implementation of benefit package recommendations is optional and these requests must be approved, denied or modified.
Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including:

- Determination of scope of coverage
- Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc.
- Identification of impacted members and trading partners.

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not at level 3 because the system poses limitations on the ease of implementing new benefits and the ability to blend benefits and external clinical data is not available to the process.

Manage Rate Setting (PG03)

MITA Business Process Description

The **Manage Rate Setting** Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program.

IME Business Process Description

Manage Rate Setting (PG03)

The Established Rate Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because processes are still primarily manual, and there is no data standard utilized by all systems or interfaces.

Develop Agency Goals and Objectives (PG04)

MITA Business Process Description

The **Develop Agency Goals and Objectives** business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary. Changes to goals and objectives could be warranted for example, under a new administration; or in response to changes in demographics, public opinion or medical industry trends; or in response to regional or national disasters.

IME Business Process Description

The **Develop Agency Goals and Objectives** business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary for the Iowa Medicaid Enterprise. Changes to goals and objectives could be warranted for example, under a new administration; or in response to changes in demographics, public opinion, legislative directives or medical industry trends; or in response to regional or national disasters.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. There is currently no formal process for setting agency goals and objectives. When this activity does take place it is a "siloed", manual process that occurs independently in both IME Policy and DHS Policy.

Develop and Maintain Program Policy (PG05)

MITA Business Process Description

The **Develop and Maintain Program Policy** Business Process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as: federal or state statutes and regulations; governing board or commission directives; Quality Improvement Organization's findings; federal or state audits; enterprise decisions; and consumer pressure.

Develop and Maintain Program Policy (PG05)

IME Business Process Description

The **Develop and Maintain Program Policy** Business Process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as: federal or state statutes and regulations; governing board or commission directives; Quality Improvement Organization's findings; federal or state audits; enterprise decisions; directors office and consumer pressure.

Note: There are two major groups of policy in IME: those related to the State Plan and those related to Administrative rules. The development and maintenance of the State Plan is documented in Maintain State Plan. The development and maintenance of Administrative Rules is documented in the **Develop and Maintain Program Policy** process. The area of IME primarily responsible for developing both groups of policy is the same (IME Policy). DHS Eligibility Policy participates in portions of the overall process of maintaining the Administrative Rules and independently creates policy related to eligibility. DHS Director's Office, DHS Council, and the Legislative Rules Committee also reviews and approves final policy.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is a mix of automated and manual process steps.

Maintain State Plan (PG06)

MITA Business Process Description

The **Maintain State Plan** business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.

IME Business Process Description

The **Maintain State Plan** business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.

Note: There are two major groups of policy in IME: those related to the State Plan and those related to Administrative rules. The development and maintenance of Administrative Rules is documented in the **Develop and Maintain Program Policy** process. The area of IME primarily responsible for developing both groups of policy is the same (IME Policy). DHS Eligibility Policy participates in portions of the overall process of maintaining the State Plan and independently creates policy related to eligibility. DHS Director's Office and the Governor's Office also reviews and approves the final

Maintain State Plan (PG06)

plan.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is a mix of automated and manual process steps.

Formulate Budget (PG07)

MITA Business Process 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.

IME Business Process Description

The IME **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.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because data to support this process must be drawn from multiple systems and these systems and related interfaces do not currently conform to a unified set of data standards; lack of transparency has resulted in a "siloed" nature to the organization of the data

Manage FFP for MMIS (PG08)

MITA Business Process Description

The Federal government allows funding for the design, development, maintenance, and operation of a federally certified MMIS.

The **Manage Federal Financial Participation for MMIS** business process oversees reporting and monitoring of Advance Planning Documents and other program documents necessary to secure and maintain federal financial participation.

IME Business Process Description

Manage FFP for MMIS (PG08)

The Federal government allows funding for the design, development, maintenance, and operation of a federally certified MMIS.

The **Manage Federal Financial Participation for MMIS** business process oversees reporting and monitoring of Advance Planning Documents and other program documents necessary to secure and maintain federal financial participation.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because data to support this process must be drawn from multiple systems and these systems and related interfaces do not currently conform to a unified set of data standards this contributes to a uncertainty as to whether the process is operating at a level that benefits IME to the fullest possible extent.

Manage F-MAP (PG09)

MITA Business Process Description

The **Manage F-MAP** business process periodically assesses current F-MAP for benefits and administrative services to determine compliance with federal regulations and state objectives.

IME Business Process Description

The IME **Manage F-MAP** business process periodically assesses current F-MAP for benefits and administrative services to determine compliance with federal regulations and state objectives.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because data to support this process must be drawn from multiple systems and these systems and related interfaces do not currently conform to a unified set of data standards.

Manage State Funds (PG10)

MITA Business Process Description

The **Manage State Funds** business process oversees Medicaid State funds and ensures accuracy in the allocation of funds and the reporting of funding sources.
Funding for Medicaid services may come from a variety of sources, and often State funds are spread

Manage State Funds (PG10)

across State agency administrations such as Mental Health, Aging, Substance Abuse, physical health, and across State counties and local jurisdictions. The **Manage State Funds** monitors State funds through ongoing tracking and reporting of expenditures and corrects any improperly charged expenditure of funds. It also deals with projected and actual over and under allocations of funds.

IME Business Process Description

The IME **Manage State Funds** business process oversees Medicaid State funds and ensures accuracy in the allocation of funds and the reporting of funding sources.
Funding for Medicaid services may come from a variety of sources, and often State funds are spread across State agency administrations such as Mental Health, Aging, Substance Abuse, physical health, and across State counties and local jurisdictions. The **Manage State Funds** monitors State funds through ongoing tracking and reporting of expenditures and corrects any improperly charged expenditures of funds. It also deals with projected and actual over and under allocations of funds.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because data to support this process must be drawn from multiple systems and these systems and related interfaces do not currently conform to a unified set of data standards.

Manage 1099s (PG11)

MITA Business Process Description

The **Manage 1099s** business process describes the process by which 1099s are handled, including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single Social Security Number or Federal Tax ID Number.
The **Manage 1099s** process receives payment and/or recoupment data from the **Price Claim/Value Encounter** Process or from the **Perform Accounting Functions** process.
The **Manage 1099s** process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the **Send Outbound Transaction** process. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.

IME Business Process Description

The **Manage 1099s** business process is handled by CORE and Provider Services. This business process describes the process by which 1099s are handled, including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single

Manage 1099s (PG11)

Social Security Number or Federal Tax ID Number.
The **Manage 1099s** process receives payment and/or recoupment data from the **Price Claim/Value Encounter** Process or from the **Perform Accounting Functions** process.
The **Manage 1099s** process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the Send Outbound Transaction process. Error notifications and requests for corrections are received via **Manage Provider Communications,** are researched for validity, and result in the generation of a corrected 1099 or a brief explanation of findings.

Note: 1099s for Non-emergency transportation claims are processed by DHS.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because while processing of 1099s within IME is centralized, 1099s for non-emergency medical transportation providers are produced in DHS in an unrelated process (a separate silo).

Generate Financial and Program Analysis/Report (PG12)

MITA Business Process Description

It is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established are meeting the needs of the member population and are performing according to the intent of the legislative laws or Federal reporting requirements.
The **Generate Financial & Program Analysis/Report** process begins with a request for information or a time table for scheduled correspondence. The process includes defining the required reports format, content, frequency and media, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy),retrieving data from multiple sources, e.g., **Manage Payment History**; **Maintain Member Information**;
Manage Provider Information; and **Maintain Benefits/Reference Repository**; compiling the retrieved data, compiling the data, and formatting into the required data set, which is sent to the **Send Outbound Transaction** for generation into an outbound transaction.
NOTE: This process does not include maintaining the benefits, reference, or program information. Maintenance of the benefits and reference information is covered under a separate business process.

IME Business Process Description

It is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established are meeting the needs of the member population and are performing according to the intent of the legislative laws or Federal reporting requirements.

Generate Financial and Program Analysis/Report (PG12)

The **Generate Financial & Program Analysis/Report** process begins with a request for information or a timetable for scheduled correspondence. The process includes defining the required reports format, content, frequency and media, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy), retrieving data from multiple sources, e.g., **Manage Payment History**; **Manage Member Information**; **Manage Provider Information**; and **Maintain Benefits/Reference Information**; compiling the retrieved data, compiling the data, and formatting into the required data set, which is sent to the Send Outbound Transaction**.**

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. While the generation of most reports is automated. The process is still siloed and internal data standards have not yet been fully implemented.

Maintain Benefits/Reference Information (PG13)

MITA Business Process Description

The **Maintain Benefits/Reference Information** process is triggered by any addition or adjustment that is referenced or used during the **Edit Claim/Encounter**, **Audit Claim/Encounter,** or **Price Claim/Encounter**. It can also be triggered by the addition of a new program, or the change to an existing program due to the passage of new State or Federal legislation, or budgetary changes. The process includes revising code information including HCPCS, CPT, NDC, and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the **Manage Prospective & Current Member Communication**, updating/adding provider information from the **Manage Provider Information**, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the receive inbound transaction.

IME Business Process Description

The **Maintain Benefits/Reference Information** process is handled by CORE and DHS DDM. This process triggered by any addition or adjustment that is referenced or used during the **Edit Claim/Encounter**, **Audit Claim/Encounter,** or **Price Claim/Encounter**. It can also be triggered by the addition of a new program, or the change to an existing program due to the passage of new State or Federal legislation, or budgetary changes. The process includes revising code information including HCPCS, CPT, NDC, and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the **Manage Applicant & Member Communication**, updating/adding provider information from the **Manage Provider Information**, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the Receive Inbound Transaction.

IME As-Is Maturity Level	Level 2

Maintain Benefits/Reference Information (PG13)

Fully meets Level 1 capabilities. Not fully at level 2 due to the siloed nature of the data. While data is not duplicative, it is stored in multiple data stores.

Manage Program Information (PG14)

MITA Business Process Description

The **Manage Program Information** business process is responsible for managing all the operational aspects of the Program Information data store, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions.

The Program Information data store receives requests to add, delete, or change data in program records. The data store validates data upload requests, applies instructions, and tracks activity.

The Program Information data store provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, through communication vehicles such as batch record transfers, responses to queries, and "publish and subscribe" services.

IME Business Process Description

The **Manage Program Information** business process is handled by most units/departments in the Iowa MITA Medicaid Enterprise. This process is responsible for managing all the operational aspects of the Program Information data store, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions.

The Program Information data store receives requests to add, delete, or change data in program records. The data store validates data upload requests, applies instructions, and tracks activity.

The Program Information data store provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, through communication vehicles such as batch record transfers, responses to queries, and "publish and subscribe" services.

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities.

Perform Accounting Functions (PG15)

MITA Business Process Description

Currently States use a variety of solutions including outsourcing to another Department or use of a COTS package. Activities included in this process can be as follows:

- Periodic reconciliations between MMIS and the system(s) that performs accounting functions
- Assign account coding to transactions processed in MMIS
- Process accounts payable invoices created in the MMIS.
- Process accounts payable invoices created in Accounting System (gross adjustments or other service payments not processed through MMIS, and administrative payables)
- Load accounts payable data (warrant number, date, etc.) to MMIS
- Manage canceled/voided/stale dated warrants
- Perform payroll activities
- Process accounts receivable (estate recovery, co-pay, drug rebate, recoupment, TPL recovery, and Member premiums)
- Manage cash receipting process
- Manage payment offset process to collect receivables
- Develops and maintain cost allocation plans
- Manages draws on letters of credit
- Manages disbursement of federal administrative cost reimbursements to other entities
- Respond to inquiries concerning accounting activities

IME Business Process Description

IME uses a variety of solutions including outsourcing to another Department or use of a COTS package. Activities included in this process can be as follows:

- Periodic reconciliations between MMIS and the system(s) that performs accounting functions
- Assign account coding to transactions processed in MMIS
- Process accounts payable invoices created in the MMIS.
- Process accounts payable transactions created in Accounting System (gross adjustments or other service payments not processed through MMIS, and administrative payables, HIPP)
- Load accounts payable data (check number, date, etc.) to MMIS
- Manage canceled/voided/stale dated checks
- Perform payroll activities
- Process accounts receivable in various systems (e.g., refunds, non-federal share from the counties, lien recovery, estate recovery, co-pay, drug rebate, recoupment, and Member premiums)
- Manage cash receipting process
- Manage payment offset process to collect receivables
- Develops and maintain cost allocation plans
- Manages draws on letters of credit
- Manages disbursement of federal administrative cost reimbursements to other entities
- Respond to inquiries concerning accounting activities

Perform Accounting Functions (PG15)

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. . Not fully at Level 2 because the process is "siloed" across multiple units and multiple platforms; data across platforms does not currently conform to a unified set of data standards.

Develop and Manage Performance Measures and Reporting (PG16)

MITA Business Process Description

The **Develop and Manage Performance Measures and Reporting** process involves the design, implementation, and maintenance of mechanisms and measures to be used to monitor the business activities and performance of the Medicaid enterprise's processes and programs. This includes the steps involved in defining the criteria by which activities and programs will be measured and developing the reports and other mechanisms that will be used by the **Monitor Performance and Business Activity** process to track activity and effectiveness at all levels of monitoring.

Examples of performance measures and associated reports may be things such as:
Goal: To assure that prompt and accurate payments are made to providers. Measurement: Pay or deny 95% of all clean claims within 30 days of receipt. Mechanism: Weekly report on claims processing timelines.

Goal: Accurately and efficiently draw and report funds in accordance with the federal Cash Management
Improvement Act (CMIA) and general cash management principles and timeframes to maximize non-general fund recovery. Measurement: Draw 98% of funds with the minimum time allowed under CMIA. Mechanism: Monthly report on funds drawn.

Goal: Improve health care outcomes for Medicaid members. Measurement: Reduce emergency room visits by ten percent by assigning a primary care case manager. Mechanism: Monthly report comparing emergency room usage by member for the period prior to and after PCCM assignment.

IME Business Process Description

The **Develop and Manage Performance Measures and Reporting** process involves the design, implementation, and maintenance of mechanisms and measures to be used to monitor the business activities and performance of the Medicaid enterprise's processes and programs. This includes the steps involved in defining the criteria by which activities and programs will be measured and developing the reports and other mechanisms that will be used by the **Monitor Performance and Business Activity** process to track activity and effectiveness at all levels of monitoring.

Develop and Manage Performance Measures and Reporting (PG16)

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Responsibility lies with the unit managers utilizing a defined process. Data to support this process must be drawn from multiple systems and these systems and related interfaces do not currently conform to a unified set of data standards; and the process is primarily manual.

Monitor Performance and Business Activity (PG17)

MITA Business Process Description

To Be Developed

IME Business Process Description

The Iowa **Monitor Performance and Business Activity** process begins with the receipt of data and/or the occurrence of a predetermined time to acquire data for the purposes of measuring performance and business activity. The data that defines a measurement and the format in which to record it is received from the **Develop and Manage Performance Measures and Reporting** process. Data needed to execute measurements may be received from other Enterprise processes, contractors, or external entities (e.g., **Manage Program Integrity Case**, Member Services contractor, etc.) Data is gathered either by accessing information in Enterprise data stores or by carrying out interviews, audits, or performance reviews and is processed into the required format. Results are distributed to predetermined users and processes such as **Develop Agency Goals and Objectives**, or **Develop and Maintain Program Policy**

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because data is received from multiple sources (other agencies, contractors), data across platforms (within and without IME) does not currently conform to a unified set of data standards; Contractors are self reporting and there is no tool to support verification of results.

Draw and Report FFP (PG18)

MITA Business Process Description

The **Draw and Report FFP** business process involves the activities to assure that federal funds are properly drawn and reported to CMS. The state is responsible for assuring that the correct FFP rate is applied to all expenditures in determining the amount of federal funds to draw. When CMS has

Draw and Report FFP (PG18)

approved a State Plan, it makes quarterly grant awards to the state to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the state to draw federal funds as needed to pay the federal share of disbursements. The state receives federal financial participation in expenditures for the Medicaid and SCHIP programs.

CMS can decrease grant awards because of an underestimate or overestimate for prior quarters.

Payment of a claim or any portion of a claim for FFP can be deferred or disallowed if CMS determines that the FFP claim is incorrectly reported or is not a valid Medicaid or SCHIP expenditure.

IME Business Process Description

The **Draw and Report FFP** business process involves the activities to assure that federal funds are properly drawn and reported to CMS. The state is responsible for assuring that the correct FFP rate is applied to all expenditures in determining the amount of federal funds to draw. When CMS has approved a State Plan, it makes quarterly grant awards to the state to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the state to draw federal funds as needed to pay the federal share of disbursements. The state receives federal financial participation in expenditures.

CMS can increase or decrease grant awards because of an underestimate or overestimate for prior quarters.

Payment of a claim or any portion of a claim for FFP can be deferred or disallowed if CMS determines that the FFP claim is incorrectly reported or is not a valid expenditure.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because data across platforms does not currently conform to a unified set of data standards and the resulting necessity to reconcile data is costly and inefficient.

Manage FFP for Services (PG19)

MITA Business Process Description

The **Manage FFP for Services** business process applies rules for assigning the correct Federal Medical Assistance Percentages (FMAP) rate to service expenditures and recoveries documented by the Medicaid enterprise.

FFP for expenditures for medical services under the Medicaid enterprise is dependent on the nature of

Manage FFP for Services (PG19)

the service and the eligibility of the beneficiary. The FMAP rate applies to Medicaid expenditures for services covered under the State Plan with the exception of things such as:

- Family planning services for which FFP is 90%
- Services provided through Indian Health Service facilities for which FFP is 100%
- Services provided to members eligible under the optional Breast and Cervical Cancer program for which FFP is based on SCHIP Enhanced FMAP rate
- Medicare Part B premiums for Qualified Individuals for which FFP is 100% unless the allotment is exceeded and then the FFP is 0%
- Transportation provided per the requirements of 42 CFR431.53 for which FFP is 50%
- FFP for expenditures for medical services under the SCHIP program is based on the Enhanced Federal Medical Assistance Percentages" (enhanced FMAP).

Recoveries of expenditures are assigned the same FFP rate as the FFP rate in effect at the time of the expenditure.

IME Business Process Description

The **Manage FFP for Services** business process applies rules for assigning the correct Federal Medical Assistance Percentages (FMAP) rate to service expenditures and recoveries documented by the Medicaid enterprise.

FFP for expenditures for medical services under the Medicaid enterprise is dependent on the nature of the service and the eligibility of the beneficiary. The FMAP rate applies to Medicaid expenditures for services covered under the State Plan with the exception of things such as:

- Family planning services for which FFP is 90%
- Services provided through Indian Health Service facilities for which FFP is 100%
- Services provided to members eligible under the optional Breast and Cervical Cancer program for which FFP is based on SCHIP Enhanced FMAP rate
- Medicare Part B premiums for Qualified Individuals for which FFP is 100% unless the allotment is exceeded and then the FFP is 0%
- Transportation provided per the requirements of 42 CFR431.53 for which FFP is 50%
- FFP for expenditures for medical services under the SCHIP program is based on the Enhanced Federal Medical Assistance Percentages'' (enhanced FMAP).
- Refugee Medical Services-100% FFP
- Money follows the person-special enhanced FFP

Recoveries of expenditures are assigned the same FFP rate as the FFP rate in effect at the time of the expenditure.

IME As-Is Maturity Level	Level 1

Manage FFP for Services (PG19)
Not fully at Level 2 because there is currently no functionality to verify appropriate FMAP rate for services and data across platforms does not currently conform to a unified set of data standards.

Manage Legislative Communication (PGIA01)	
MITA Business Process Description	
This is an IME Specific Business Process.	
IME Business Process Description	
The Iowa Legislature plays a key role in setting the strategic and tactical direction for IME. IME (Unit Managers and the IME Policy Staff) and DHS Eligibility Policy are involved in: A. Responding to all types of requests from the legislature (e.g., request for bill review, fiscal (note) information, general technical assistance). B. Monitoring legislative activity for bills that address policy staffing or systems that impact IME. Requires the Tracking of bills as they move through the legislative process. C. Giving input into the health and human services components of the governor's proposals. D. Developing the department priorities package for the budget process. E. Development of legislative priorities and proposals for legislation originating within IME	
IME As-Is Maturity Level	Level 2
Fully meets level 2 capabilities.	

3.2.1.3.6 Business Relationship Management

Establish Business Relationship (BR01)
MITA Business Process Description
The **Establish Business Relationship** business process encompasses activities undertaken by the State Medicaid enterprise to enter into business partner relationships with other stakeholders for the purpose of exchanging data. These include Memoranda of Understanding (MOU) with other agencies; electronic data interchange agreements with providers, managed care organizations, and others; and CMS, other Federal agencies, and Regional Health Information Organizations (RHIO).

Establish Business Relationship (BR01)

IME Business Process Description

The **Establish Business Relationship** business process encompasses activities undertaken by the State Medicaid enterprise to enter into business partner relationships with other stakeholders for the purpose of exchanging data. These include Memoranda of Understanding (MOU) and Service Level Agreements (SLA) with other agencies (e.g., Department of Public Health, Licensing Boards); limited service organizations, and others; and CMS (i.e., MDS), other Federal agencies.

Note: EDI with providers is through clearing houses. IME does not have agreements with the providers. The clearing house establishes these agreements.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is primarily manual.

Manage Business Relationship (BR02)

MITA Business Process Description

The **Manage Business Relationship** business process maintains the agreement between the State Medicaid enterprise and the other party. This includes routine changes to required information such as authorized signers, addresses, terms of agreement, and data exchange standards.

IME Business Process Description

The **Manage Business Relationship** business process maintains the agreement between the State Medicaid enterprise and the other party. This includes routine changes to required information such as authorized signers, addresses, terms of agreement, and data exchange standards.

Note: EDI with providers is through clearing houses. IME does not have agreements with the providers. The clearing house establishes these agreements.

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is primarily manual.

Terminate Business Relationship (BR03)

MITA Business Process Description

Terminate Business Relationship (BR03)	
The **Terminate Business Relationship** business process cancels the agreement between the State Medicaid agency and the business or trading partner.	
IME Business Process Description	
The **Terminate Business Relationship** business process cancels the agreement between the State Medicaid agency and the business or trading partner.	
IME As-Is Maturity Level	Level 1
Fully meets Level 1 capabilities. Not fully at Level 2 because the process is primarily manual.	

Manage Business Relationship Communications (BR04)	
MITA Business Process Description	
The **Manage Business Relationship Communication** business process produces routine and ad hoc communications between the business partners.	
IME Business Process Description	
The **Manage Business Relationship Communication** business process produces routine and ad hoc communications between the business partners. Note: EDI with providers is through clearing houses. IME does not have agreements with the providers. The clearing house establishes these agreements.	
IME As-Is Maturity Level	Level 1
Fully meets Level 1 capabilities. Not fully at Level 2 because the process is primarily manual.	

3.2.1.3.7 Program Integrity Management

Identify Candidate Case (PI01)
MITA Business Process Description

Identify Candidate Case (PI01)

The **Identify Candidate Case** business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable/ unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits.

Candidate cases may be identified by:

- Provider utilization review
- Provider compliance review
- Contractor utilization review [includes MCOs]
- Contractor compliance review
- Member utilization review
- Investigation of potential fraud review
- Drug utilization review
- Quality review
- Performance review
- Erroneous payment
- Contract review
- Audit Review
- Other

Each type of case is driven by different State criteria and rules, different relationships, and different data.

IME Business Process Description

The **Identify Candidate Case** business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable/ unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Responsibility for the process is centralized, for the most part in SURS. Medical Services and IME policy provide support. When a case is determined as resulting in a fraud or criminal situation, the case is turned over to either the DIA Bureau of Economic Fraud (Member) or the DIA MFCU (Provider), as appropriate.

While many cases are identified as a result of scheduled review activities information received from sources outside the unit can also trigger identification of a case. Such information can be forwarded to the SURS unit as a result of standard IME activities many of which are part of the **Monitor Performance and Business Activity** process (e.g., processing returned EOBs), from the Healthcare Task Force Unit, or from the DIA Fraud Hotline. In some instances, a case may be initiated by either the DIA Bureau of Economic Fraud (BEF) or the DIA MFCU without having been forwarded to them by the SURS unit. In such an instance, the BEF or the MFCU may also trigger the **Identify Candidate Case** process by requesting that the SURS unit provide support by conducting review activities that are a part of this process.

Identify Candidate Case (PI01)

Candidate cases may be identified by:

- Provider utilization review
- Provider Inquiry
- Provider compliance review
- Contractor utilization review [includes MCOs]
- Contractor compliance review
- Member utilization review (includes member lock-in)
- Member Inquiry
- Investigation of potential fraud review
- Drug utilization review
- Quality review
- Performance review
- Erroneous payment
- Contract review
- Audit Review
- Other state work plan review (SURS)
- Other

Each type of case is driven by different IME criteria and rules, different relationships, and different data.

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not fully at Level 3
Note: Data across Fiscal Management system platforms do not currently conform to a unified set of data standards making identification of candidate cases more difficult. Systems that support the SURS unit do conform to data standards.

Manage Program Integrity Case (PI02)

MITA Business Process Description

The Program Integrity, **Manage Case** business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or member from the Medicaid program; or the case may be terminated or suspended.

Individual state policy determines what evidence is needed to support different types of cases:

- Provider utilization review
- Provider compliance review
- Contractor utilization review [includes MCOs]

Manage Program Integrity Case (PI02)

- Contractor compliance review
- Beneficiary utilization review
- Investigation of potential fraud review
- Drug utilization review
- Quality review
- Performance review
- Contract review
- Erroneous payment review

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.

IME Business Process Description

The **Manage Program Integrity Case** business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or member from the Medicaid program; or the case may be terminated or suspended. Responsibility for the process is centralized, for the most part in SURS. Medical Services and IME policy provide support. When a case is determined as resulting in a fraud or criminal situation, the case is turned over to either the DIA Bureau of Economic Fraud (Member) or the DIA MFCU (Provider), as appropriate.

Individual state policy determines what evidence is needed to support different types of cases:

- Provider utilization review
- Provider Inquiry
- Provider compliance review
- Contractor utilization review [includes MCOs]
- Contractor compliance review
- Member utilization review (includes member lock-in)
- Member Inquiry
- Investigation of potential fraud review
- Drug utilization review
- Quality review
- Performance review
- Erroneous payment
- Contract review
- Audit Review
- Other state work plan review (SURS)
- Other

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.

Manage Program Integrity Case (PI02)	
IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the process is manual.

3.2.1.3.8 Care Management

Establish Case (CM01)

MITA Business Process 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.

IME Business Process Description

The IME 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 (IME Policy defines procedure guidelines. Medical Services, IMWs, Case Managers (Local office, or case managers contracted as providers), HCBS specialists, County CPCs – funding, Financial Management Service Agency*
  - Home and Community-Based Services
  - Long Term Care
  - Remedial Services
  - Habilitation Services

Establish Case (CM01)

- Children's Mental Health
- Money Follows the Person
- Pace

- *Disease management (Medical Services)*
- *Early Periodic Screening, Diagnosis, and Treatment (EPSDT) (automated)*

Each type of case is driven by state-specific criteria and rules, different relationships, and different data.
Identification of care management touches more care management programs than does Managing cases (e.g., TCM)

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not fully at Level 3 due to the mix of manual and automated process steps and the fact that the process is not a shared service.

Manage Care Management Case (CM02)

MITA Business Process 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

Manage Care Management Case (CM02)

IME Business Process Description

The IME **Manage Care Management 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 with the member*
- *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

Note: Lock-in cases are identified in the Program Integrity, **Identify Case** process and are managed here in the **Manage Care Management Case** process.

IME As-Is Maturity Level	Level 2

Fully meets Level 2 capabilities. Not fully at Level 3 due to the mix of manual and automated process steps and the fact that the process is not a shared service.

Manage Medicaid Population Health (CM03)

MITA Business Process Description

This business process designs and implements strategies to improve general population health by targeting individuals by cultural or diagnostic or other demographic indicators. The input to this process are census, vital statistics, immigration, and other data sources. The outputs are educational

Manage Medicaid Population Health (CM03)

materials, communications, and other media.
To Be Developed.

IME Business Process Description

The **Manage Medicaid Population Health** business process designs and implements strategies to improve general population health by targeting individuals by cultural, diagnostic, or other demographic indicators. The inputs to this process are census, vital statistics, immigration, EPSDT reports, and other data sources. The outputs are educational materials, communications, and other media.
MVM (Medicaid Value Management Project) – carries out a lot of the activities involved in this process
HEDIS measures results – input (analysis)
CAHPS (Consumer Assessment of Healthcare Providers and Systems) – input (analysis)
IDPH Birth Match – input (analysis)

IME As-Is Maturity Level	Level 1

Fully meets Level 1 capabilities. Not fully at Level 2 because the data analysis is primarily manual.

Manage Registry (CMO4)

MITA Business Process Description

This business process operates a registry (e.g., immunizations, cancer), receives continuous updates, responds to inquiries, and provides access to authorized parties.
To Be Developed.

IME Business Process Description

This IME business process operates a registry (e.g., immunizations, cancer), receives continuous updates, responds to inquiries, and provides access to authorized parties.

All known health data related registries are maintained outside of IME (immunizations, cancer, BCCP).

Note: The process steps documented in this template (sections C through I.2 and N) relate to Medical Services and Pharmacy Services responses to requests for information. It does not address the maintenance of the data collections under the responsibility of these areas. Medical Services and Pharmacy Services maintain collections of data related to their responsibilities and respond to outside requests for information.

IME As-Is Maturity Level	N/A

Manage Registry (CMO4)
All known health data related registries are maintained outside of IME.

3.2.2 IME As-Is Technical Architecture

FOX based the Technical Assessment on Part III – Technical Architecture, of the MITA Framework 2.0. This section of the framework is undergoing extensive revision. Subsequent State Self-Assessments will work with the revised Technical Architecture. This section is divided into two parts. The first section is a table that allows the reader to see, at a glance, the As-Is level of maturity assessed for each MITA Technical Function. The second section contains the detailed explanation behind the assessed maturity level for each of the seven Technical Areas that support Iowa's Medicaid program. For each Technical Function, there is a description of the function as it exists in IME, the assessed maturity level, and a brief explanation behind the assessed maturity level.

See 5.2 Technical Questionnaire and Responses for an example of the Technical Questionnaire used to collect the data used as input to the Technical Assessment and the responses to the questionnaire.

3.2.2.1 IME System and Technology Capability Matrix – Summary Level

The following table is an abbreviated form of the MITA Technical Capabilities Matrix. While a complete matrix contains descriptions at each level, this table shows the level determinations resulting from the assessment using a simple indicator (shaded cell in the applicable maturity level column), but does not contain the reasoning behind the assessed level.

No.	Technical Function	Capabilities				
		Level 1	Level 2	Level 3	Level 4	Level 5
B.0	**Business Enabling Services Technical Area**					
B.1	Forms Management					
B.2	Workflow Management					
B.3	Business Process Management (BPM)					
B.4	Business Relationship Management (BRM)					

No.	Technical Function	Capabilities				
		Level 1	Level 2	Level 3	Level 4	Level 5
B.5	Foreign Language Support					
B.6	Decision Support					
B.6.1	Data Warehouse					
B.6.2	Data Marts					
B.6.3	Ad hoc Reporting					
B.6.4	Data Mining					
B.6.5	Statistical Analysis					
B.6.6	Neural Network Tools					
A.0	**Access Channels**					
A.1	Portal Access					
A.2	Support for Access Devices					
I.0	**Interoperability**					
I.1	Service-Oriented Architecture					
I.1.1	Service Structuring and Invocation					
I.1.2	Enterprise Service Bus					
I.1.3	Orchestration and Composition					
I.2	Standards-Based Data Exchange					
1.3	Integration of Legacy Systems					
D.0	**Data Management and Sharing**					
D.1	Data Exchange Across Multiple Organizations					
D.2	Adoption of Data Standards					
P.0	**Performance Measurement**					
P.1	Performance Data Collection and Reporting					
P.2	Dashboard Generation					
S.0	**Security and Privacy**					
S.1	Authentication					
S.2	Authentication Devices					
S.3	Authorization and Access Control					
S.4	Intrusion Detection					

No.	Technical Function	Capabilities				
		Level 1	Level 2	Level 3	Level 4	Level 5
S.5	Logging and Auditing					
S.6	Privacy					
F.0	**Flexibility – Adaptability and Extensibility**					
F.1	Rules-Driven Processing					
F.2	Extensibility					
F.3	Automate Configuration and Reconfiguration Services					
F.4	Introduction of New Technology					

3.2.2.2 IME Technical Function Descriptions and As-Is Maturity Assessments

There are seven sub-sections, one for each of the Technical Areas specified in Framework 2.0. Each Technical Area is broken down into Technical Functions. The assessment information is presented in a table format, one table for each Technical Function. Each table contains:

- A brief description of the MITA technical function and the capabilities defined for that function from the MITA Framework 2.0 Technical Capability Matrix (TCM)
- A description of the technical function as it applies to IME
- The assessed As-Is maturity level of the technical function for IME (represented by a single number)
- A statement detailing the explanation behind the assessed level for IME

The Framework 2.0 TCM is not as mature as the Business Capability Matrix. For those technical functions where MITA did not define technical maturity for levels 1, 2, or 3, FOX assessed the function based on the following principles.

- **Level 1** – If the technical function or technical area is not automated and performed primarily by manual processes or data comes into the system through paper or fax, FOX assessed the function at Level 1.
- **Level 2** – If the technical function or technical area is automated, but using a legacy system; data enters the system primarily through tapes, disks, or proprietary systems and using non-standard/proprietary formats; FOX assessed the function at Level 2.
- **Level 3** – FOX assessed the Level 3 from a Service Oriented Architecture (SOA) perspective.

- If the technical function is fully automated, is following National standards, and is serviced oriented, FOX assessed the function at Level 3.
- If the technical function is fully automated, uses National standards, may meet other Level 3, or higher, capabilities, but is not service oriented, FOX assessed the function at Level 2.

The reader should assume, if the explanation of the assessed maturity level references a level for which capabilities were not defined, that the above principles were used.

3.2.2.2.1 B.0 – Business Enabling Services

B.1 – Forms Management

MITA Technical Function Description and Capabilities

The Forms Management technical function focuses on the ability of an enterprise to receive data via a form.

- Level 1 Manual data entry on hardcopy forms
- Level 2 Online data entry on electronic forms

IME Technical Function Description

Iowa uses both Electronic forms and Hardcopy forms. A large percentage of claims are received electronically. Iowa uses Dakota Imaging software for scanning and recognition (OCR) of claims and other paper documents. Computer Output to Laser Disk (COLD) is used to index electronic versions of the scanned documents to electronic media. Where legal requirements include paper notification, Iowa still performs paper notification. Iowa also processes some forms in Adobe Forms. Iowa currently accepts electronic signatures as acceptable verification. Iowa utilizes one its contractors (CORE) to handle the receipt and processing of paper claims and forms. This includes Direct Data Entry (DDE) for IME Optical Character Recognition (OCR) scanning.

Forms related to administrative processes (security access to facilities, applications, etc.) are primarily handled by electronic means but a portion of these require re-entry of information into the target application.

Authorization requests are generally transmitted by phone, fax or paper and are manually entered into the target application for primary tracking.

A high percentage of provider forms (service authorization requests, etc.) are faxed or phoned in the IME.

IME As-Is Maturity Level	Level 1

While Iowa is primarily performing forms management at the maturity level 2, there are still some processes that continue to use manual data entry from hardcopy forms. As long as Iowa continues to perform forms management using hardcopy forms it will be operating at maturity level 1.

B.2 – Workflow Management

MITA Technical Function Description and Capabilities

The Workflow Management technical function focuses on the capabilities of an enterprise to route files and data to individuals and business processes

- Level 1 Manual routing of hardcopy files to individuals involved in processing.
- Level 2 Electronic routing of files to business processes and individuals involved in processing. Responsible for processing completion and other individual and business processes

IME Technical Function Description

Iowa utilizes the OnBase (Hyland Software) workflow management tool in relatively widespread areas of the IME. In general, Iowa would gain higher levels of workflow management effectiveness by utilizing OnBase in additional functions both within the IME and other state agencies and departments engaged in MITA business processes.

IME As-Is Maturity Level	Level 2

Iowa utilizes formal Workflow management system tools in IME. Although implementation and use of similar tools is less evident in other areas of the state's Medicaid program.

B.3 – Business Process Management (BPM)

MITA Technical Function Description and Capabilities

The Business Process Management technical function focuses on the capabilities of an enterprise to manage their business processes.

- Level 1 Manual by the user
- Level 3 Specification and management of business processes is in conformance with MITA BPM standards (e.g., Business Process Execution Language [BPEL])

IME Technical Function Description

Iowa currently uses an enterprise business model that aligns somewhat with the MITA business process model.

IME As-Is Maturity Level	Level 1

Iowa's business process management (BPM) is a mix of both manual and automated means by the users. The substantial majority of BPM is manual.

B.4 – Business Relationship Management (BRM)

MITA Technical Function Description and Capabilities

The Business Relationship Management technical function focuses on the capabilities of an enterprise to manage their business relationships.

- Level 1 Manual (e.g. by attaching annotations to case files.)
- Level 3 Basic BRM, including tracking relationships between Medicaid system users (e.g., beneficiaries and providers) and the services they have requested and received
- At level 4 Advanced BRM, which includes basic BRM plus analytics support and personalization capabilities

IME Technical Function Description

Business Relationship Management in Iowa is primarily manual and data sources are not supported by standardized interfaces and may not be well integrated. While tracking of relationships between some Medicaid system users and trading partners is being done, the approach is not consistent across IME.

IME As-Is Maturity Level	Level 1

Business Relationship Management in Iowa is primarily manual.

B.5 – Foreign Language Support

MITA Technical Function Description and Capabilities

The Foreign Language Support technical function focuses on the State's capabilities to support foreign languages.

- Level 1 Manual translation of messages into supported foreign languages
- Level 3 Foreign language translation support for real-time and offline interaction with beneficiaries in designated languages

IME Technical Function Description

Iowa is comprised of increasingly diverse cultures and multiple foreign languages. For the most part, systems and interfaces with individuals whose primary language is not English are performed manually by translator personnel on the job. The primary contact to members (Member Services) utilizes a third party translator service as needed or requested. The majority of widely available published member materials are translated to Spanish, however other language translations is limited. There is some limited real-time translation within current systems.

IME As-Is Maturity Level	Level 1

Iowa does not provide much support of real-time translation of foreign languages and does not use automated systems to accomplish this.

B.6 – Decision Support

B.6.1 – Data Warehouse

MITA Technical Function Description and Capabilities

The Data Warehouse technical function is focused on the ability to extract, transform and load data from multiple databases into a data warehouse so that decision support functions can be accomplished.

- Level 3 Extracting, transforming and loading data from multiple databases into a data warehouse that conforms with the MITA Logical Data Model.

IME Technical Function Description

The Iowa Medicaid Data Warehouse is an extension to the legacy MMIS supporting the Department's analytic and reporting activities. The data warehouse utilizes a version of Microsoft's Health Services Data Model as the structure used for storing data for extraction and data analysis.

Data for the Data Warehouse is extracted from the legacy MMIS as well as other data sources throughout the Department. The data warehouse provides data for a number of subsidiary data applications including SURS, MARS, MQUIDS, etc.

IME As-Is Maturity Level	Level 2

Iowa has been using Data Warehouse technology for several years and continues to develop a fairly mature process in this area. However, as MITA Framework 2.0 does not contain a Logical Data Model, Iowa cannot be assessed at level 3 maturity.

B.6 – Decision Support

B.6.2 – Data Marts

MITA Technical Function Description and Capabilities

The Data Mart technical function is focused on the ability to import data into subsets of the data store to perform a specific purpose.

- Level 3 Importing data into data marts that conform with the MITA Logical Data Model.

IME Technical Function Description

Iowa does not utilize Data Marts as such. However, the extraction and data storage for focused use (Data Warehouse is characterized as a central aggregation of data; a data mart is a data repository that may or may not derive from a data warehouse and that emphasizes ease of access and usability for a particular designed purpose) applies to applications such as MQUIDS (Medical Services unit) and the applications maintained by the Revenue Collections unit.

IME As-Is Maturity Level	Level 2

Iowa has been involved in the development and support of the Data Warehouse for a number of years and has developed some sophisticated uses of the data stored in the DW. However, as MITA Framework 2.0 does not contain a Logical Data Model, Iowa cannot be assessed at maturity level 3.

B.6 – Decision Support

B.6.3 – Ad hoc Reporting

MITA Technical Function Description and Capabilities

The Ad hoc Reporting technical function is focused on the ability to create various reports from data within the Medicaid Enterprise.

- Level 1 Ad hoc reporting, typical using coded procedures.
- Level 2 Ad hoc reporting against databases using COTS tools.

IME Technical Function Description

Ad hoc Reports are currently generated from data stored within the Data Warehouse, the legacy MMIS and the other supporting applications maintained by the other units. SURS reports are generated from DW data using coded procedures driven by reference files. However, a majority of the Ad Hoc reports generated come from the DW.

IME As-Is Maturity Level	Level 2

Iowa has been increasingly utilizing the Data Warehouse for producing Ad Hoc reporting for a number of years and has developed some sophisticated uses of the data stored in the DW. MITA Framework 2.0 does not define Level 3 maturity for this function therefore the general guidelines were applied to this assessment. Since the State Ad hoc Reporting function is not based on Service Oriented Architecture (SOA) it was assessed at level 2.

B.6 – Decision Support

B.6.4 – Data Mining

MITA Technical Function Description

The Data Mining technical function is focused on the ability to parse large volumes of data to detect patterns in usage.

- Level 1 Data mining to detect patterns in large volumes of data, typically using coded procedures.
- Level 2 Data mining to detect patterns in large volumes of data using COTS tools.

IME Technical Function Description

Data mining usage is via the MQUIDS application (Medical Services) which acts as a data mart utilizing data primarily from data stored within the Data Warehouse.

IME As-Is Maturity Level	Level 1

Iowa is using data mining within the MQUIDS application used to support activities of the Medical Services unit (IFMC), however it is not considered a COTS tools therefore Iowa is assessed at level 1. MITA Framework 2.0 does not define Level 3 maturity for this function therefore the general guidelines were applied to this assessment.

B.6 – Decision Support

B.6.5 – Statistical Analysis

MITA Technical Function Description and Capabilities

The Statistical Analysis technical function is focused on the ability to perform statistical analysis of designated data (e.g., regression analysis).

- Level 1 Statistical analysis of designated data (e.g., regression analysis), typically using coded procedures.
- Level 2 Statistical analysis of designated data (e.g., regression analysis) using COTS tools.

IME Technical Function Description

Iowa utilizes statistical tools such as SAS and SPSS primarily for support of the Revenue Collections, SURS, and Financial Planning areas.

IME As-Is Maturity Level	Level 2

Iowa is at level 2 because SAS is used for statistical analysis for the Medicaid program.

B.6.6 – Neural Network Tools

MITA Technical Function Description and Capabilities

The Neural Network Tools technical function is focused on the ability to perform data analysis using neural network (i.e., learning) tools.

- Level 1 None
- Level 2 Analysis using neural network (e.g., learning) tools.

IME Technical Function Description

At this time Iowa does not use any neural network tools.

IME As-Is Maturity Level	Level 1

At this time Iowa does not use any neural network tools.

3.2.2.2.2 A.0 – Access Channels

A.1 – Portal Access

MITA Technical Function Description and Capabilities

The Portal Access technical function focuses on the method of access to the Medicaid business functions.

- Level 1 Beneficiary and provider access to appropriate Medicaid business functions via manual or alphanumeric devices.
- Level 2 Beneficiary and provider access to appropriate Medicaid business functions via portal with single online access point.
- Level 3 Beneficiary and provider access to appropriate Medicaid business functions via portal with single online access point.

IME Technical Function Description

Currently, State Medicaid beneficiaries gain access to appropriate medical services by personal visits, phone call inquiries to Member Services, and manual requests.
Providers have access manually, via alphanumeric device, and internet web access. There is also an interactive voice response system used for provider's access.

IME As-Is Maturity Level	Level 1

The Provider access is considered at level 2 however because beneficiary is limited to manual access Iowa has been assessed at level 1 overall for this technical function.

A.2 – Support for Access Devices

MITA Technical Function Description and Capabilities

The Support for Access Devices technical function focuses on the type of devices supported to access Medicaid services.

- Level 1 Beneficiary and provider access to services via manual submissions, alphanumeric ("green screen") devices, or EDI.
- Level 2 Beneficiary and provider access to services via browser, Kiosk, voice response system or mobile phone.
- Level 3 Beneficiary and provider access to services online via PDA.

IME Technical Function Description

Currently State Medicaid beneficiaries gain access to appropriate Medicaid business services by personal visits and manual requests.

Providers have access manually, via alphanumeric device, internet web access. There is also an interactive voice response system used for provider's access.

IME As-Is Maturity Level	Level 1

The Provider access is considered at level 2 because access to Medicaid services for Providers can be accessed via the web, however because beneficiary is limited to manual access Iowa has been assessed at level 1 overall for this technical function.

3.2.2.2.3 I.0 – Interoperability

I.1 – Service Oriented Architecture	
I.1.1 – Service Structuring and Invocation	
MITA Technical Function Description and Capabilities	
Service Structuring and Invocation is used to identify the services of the Medicaid Enterprise. It is focused on how the various services (i.e., system functions or modules) are defined and structured and how they are invoked ▪ Level 1 Non-standardized definition and invocation of services. ▪ Level 2 Service support using architecture that does not comply with published MITA service interfaces and interface standards. ▪ Level 3 Service support using architecture that complies with published MITA service interfaces and interface standards. ▪ Level 4 Services support using a cross-enterprise services registry (to be verified).	
IME Technical Function Description	
Currently Iowa does not use standardized definition and invocation of services.	
IME As-Is Maturity Level	Level 1
Currently Iowa does not use standardized definition and invocation of services.	

I.1 – Service Oriented Architecture

I.1.2 – Enterprise Service Bus

MITA Technical Function Description and Capabilities

Enterprise Service Bus focuses on the service layer that provides the capability for services to interoperate and be invoked as a chain of simple services that perform a more complex end-to-end process.

- Level 1 None or non-standardized application integration.
- Level 2 Reliable messaging, including guaranteed message delivery (without duplicates) and support for non-deliverable messages.
- Level 3 MITA compliant ESB.
- Level 4 MITA compliant ESB interoperable outside of State Medicaid agency.

IME Technical Function Description

Iowa currently does not use standardized application integration for the MMIS environment.

IME As-Is Maturity Level	Level 1

Iowa currently does not use standardized application integration for the MMIS environment and is assessed at level 1.

I.1 – Service Oriented Architecture

I.1.3 – Orchestration and Composition

MITA Technical Function Description and Capabilities

Orchestration and Composition technical area focuses on the approach to the functionality within and across the Medicaid Management Information System.

- Level 1 Non-standardized approach to orchestration and composition within and across the Medicaid Management Information System (MMIS).
- Level 3 MITA standard approach to Orchestrating and Composing services.

IME Technical Function Description

Iowa does not use standardized approach to orchestration and composition within and across the MMIS.

IME As-Is Maturity Level	Level 1

Iowa does not use a standardized approach to orchestration and composition within and across the MMIS.

I.2 – Standards Based Data Exchange

MITA Technical Function Description and Capabilities

Standards based data exchange technical area focuses on the structure of data exchanged between systems and entities.

- Level 1 Ad hoc formats for data exchange
- Level 3 Data exchange (internally and externally) using MITA Standards
- Level 5 Data exchange (internally and externally) in conformance with MITA-defined semantic data Standards (ontology based).

IME Technical Function Description

Some data exchange is accomplished using commonly defined standards (e.g., HIPAA and X12 standards). Iowa is making the effort to establish and use standard transaction sets for data exchange.

IME As-Is Maturity Level	Level 2

Iowa fully meets level 2. Iowa has some established data exchange standards.
NOTE: Capability level not provided in the MITA Framework 2.0 so the general guidelines were applied.

I.3 – Integration of Legacy Systems

MITA Technical Function Description and Capabilities

Integration of legacy systems technical area focuses on the structure of the integration of systems within the MMIS.

- Level 1 Ad hoc, point-to-point approaches to systems integration
- Level 3 Service-enabling legacy systems using MITA-standard service interfaces

IME Technical Function Description

Iowa's primary approach to system integration is point to point. Iowa implemented a Data Warehouse several years ago and has since developed some Medicaid functions on this platform. This has allowed Iowa to begin establishing some functions in a service-like format, however the legacy MMIS continues to provide point-to-point integration.

IME As-Is Maturity Level	Level 1

Iowa fully meets level 1 for this function and is well on their way to a level 2 (as determined by the general guidelines). While Iowa primarily uses point to point approaches to system integration, the introduction of the Data Warehouse platform has provided a more service-enabling environment for portions of Iowa Medicaid.

3.2.2.2.4 D.0 – Data Management and Sharing

D.1 – Data Exchange Across Multiple Organizations

MITA Technical Function Description and Capabilities

Data exchange across multiple organizations technical area is focused on data formats and methods of transmission or sharing between multiple organizations.

- Level 1 Manual data exchange between multiple organizations, sending data requests via telephone or e-mail to data processing organizations and receiving requested data in nonstandard formats and in various media (e.g., paper)
- Level 2 Electronic data exchange with multiple organizations via a MITA information hub using secure data, in which the location and format are transparent to the user and the results are delivered in a defined style that meets the user's needs
- Level 3 Electronic data exchange with multiple organizations via a MITA information hub that can perform advanced information monitoring and route alerts/alarms to communities of interest if the system detects unusual conditions

IME Technical Function Description

Data exchanged between the State and Members is primarily a paper-based manual process. Between Providers and other organizations Iowa's methods for electronic data exchange via email, CD-ROM/DVD, EDI, and web portal.

Providers have access to ELVS which provides Member Eligibility verification as well as other provider-related information.

Other State Agencies also have access to the legacy MMIS screens. In addition, the other State Agencies also have access to the Data Warehouse providing the capabilities to extract data as authorized.

IME As-Is Maturity Level	Level 1

Iowa fully meets level 1 requirements and is well on its way to meeting level 2. The data exchanges between State and Members are still primarily paper however.

D.2 – Adoption of Data Standards

MITA Technical Function Description and Capabilities

Adoption of data standards technical area is focused on the data standards the State has adopted in the Medicaid Environment.

- Level 1 No use of enterprise-wide data standards
- Level 2 Data model that conforms to the MITA model and maps data exchanged with external organizations to this model
- Level 3 Data model that conforms all shared data used by a State Medicaid agency's business processes to the MITA model
- Level 4 Data model that conforms all shared data used by a State Medicaid agency's business processes to the MITA model and includes standards for clinical data and electronic health records
- Level 5 – Data model that conforms all shared data used by a State Medicaid agency's business processes to the MITA model and that includes national standards for clinical data and electronic health records and other public health and national standards

IME Technical Function Description

Iowa has not adopted an enterprise-wide data standard at this point.

IME As-Is Maturity Level	Level 1

Iowa does not use an enterprise-wide data standard.

3.2.2.2.5 P.0 – Performance Measurement

P.1 – Performance Data Collection and Reporting	
MITA Technical Function Description and Capabilities	
Performance data collection and reporting technical area is focused on the methods and approach of the organization in collecting and reporting performance data. ▪ Level 2 Collect and report using predefined and ad hoc reporting methods and currently defined performance metrics ▪ Level 3 Define, implement, collect, and report using a set of business process–related performance metrics that conform to MITA-defined performance metrics ▪ Level 4 Generate alerts and alarms when the value of a metric falls outside limits	
IME Technical Function Description	
Iowa currently uses some predefined and ad hoc reports for performance data collection and reporting. Iowa continues to develop performance reports utilizing data from the Data Warehouse.	
IME As-Is Maturity Level	Level 2
Iowa is at level 2.	

P.2 – Dashboard Generation

MITA Technical Function Description and Capabilities

Dashboard generation technical area is focused on the presentation of the performance information and the use of summary-level methods and approach of the organization in collecting and reporting performance data.

- Level 2 Generate and display summary-level performance information (i.e., performance dashboards)
- Level 3 Generate and display summary-level performance information (i.e., performance dashboards) within a State Medicaid agency for all MITA-defined metrics
- Level 4 Generate and display summary-level performance information (i.e., performance dashboards) from external sources (e.g., other States and agencies) within a State Medicaid agency for all MITA-defined metrics

IME Technical Function Description

Iowa is doing some development work to extract and produce dashboards from the Data Warehouse. Widespread implementation and use of dashboards does not exist.

IME As-Is Maturity Level	Level 1

Iowa is fully at level 1.

3.2.2.2.6 S.0 – Security and Privacy

S.1 – Authentication	
MITA Technical Function Description and Capabilities	
Authentication technical area is focused on the methods and approach to security access of the Medicaid Environment. ▪ Level 1 Access to MMIS system capabilities via logon ID and password ▪ Level 3 User authentication using public key infrastructure in conformance with MITA-identified standards	
IME Technical Function Description	
Iowa user authentication via logon is required to access MMIS. User authentication to access MMIS requires a password.	
IME As-Is Maturity Level	Level 1
Iowa fully meets level 1 for this function. The legacy MMIS (COBOL/CICS) system uses an ad-hoc logon ID and password capabilities coupled with the Network Entry System (NES) logon level provided by the ITE.	

S.2 – Authentication Devices

MITA Technical Function Description and Capabilities

Authentication Devices technical area is focused on the equipment used to provide security to the MMIS system.

- Level 3 Support for user authentication via kiosks based on fingerprints and delivery of results to authentication and authorization functions
- Level 4 Support for user authentication via Secure ID tokens and delivery of results to authentication and authorization functions
- Level 5 Support for user authentication via kiosks based on retinal scans and delivery of results to authentication and authorization functions

IME Technical Function Description

Iowa does not currently utilize authentication devices for access to MMIS.

IME As-Is Maturity Level	Level 1

Iowa does not currently utilize authentication devices for access to MMIS.

S.3 – Authorization and Access Control

MITA Technical Function Description and Capabilities

Authentication Devices technical area is focused on the ability to use roles for security access.

- Level 2 User access to system resources depending on their role at sign-on

IME Technical Function Description

Currently Iowa uses role based user authorization and multiple layers of security access control where the user is allowed access only to MMIS resources required to do his/her job.

IME As-Is Maturity Level	Level 2

Iowa currently fully meets level 2 for this function with the role based user authorization methods in place.

S.4 – Intrusion Detection

MITA Technical Function Description and Capabilities

Intrusion detection technical area is focused on the ability of the organization to detect and control intrusion into secure systems.

- Level 1 TBD
- Level 2 TBD
- Level 3 TBD
- Level 4 TBD
- Level 5 TBD

IME Technical Function Description

Iowa does not currently use intrusion detection for MMIS security. The State does have the functionality to perform intrusion detection on a "after the fact basis" but it is not specific to MMIS.

IME As-Is Maturity Level	Level 1

Iowa does use some form of intrusion detection but is not specific to MMIS.

S.5 – Logging and Auditing

MITA Technical Function Description and Capabilities

Logging and auditing technical area is focused on the approach of the organization to logging access attempts and their methods of auditing access.

- Level 1 Manual logging and analysis
- Level 2 Access to the history of a user's activities and other management functions, including logon approvals and disapprovals and log search and playback

IME Technical Function Description

Iowa utilizes automated logging and analysis with access to a user activity history.

IME As-Is Maturity Level	Level 2

Iowa fully meets level 2 for this function with the automated logging and analysis of user activity history.

S.6 – Privacy

MITA Technical Function Description and Capabilities

Privacy technical area is focused on the approach of the organization to ensure privacy of information.

- Level 1 Procedural controls to ensure privacy of information
- Level 3 Access restriction to data elements based on defined access roles

IME Technical Function Description

Iowa currently uses procedural controls to ensure information privacy. When conectivity is established the requirements are applied but that is at the program level not the process level. There is no defined way to look at all access points within a process and identify what they are or how the data access is established.

Roles are defined by applications and views so a person would be allowed views of data based on their role assigned to the given application or view.

IME As-Is Maturity Level	Level 2

Iowa fully meets level 2 for this function. While there is no level 2 defined in Framework 2.0 Iowa uses automated legacy security functions to provide screen or view level privacy.

3.2.2.2.7 F.0 – Flexibility – Adaptability and Extensibility

F.1 – Rules Driven Processing	
MITA Technical Function Description and Capabilities	
Rules driven processing technical area is focused on the methods the State uses to apply system and business process rules and their approach to management of those rules. ▪ Level 1 Manual application of rules (and consequent inconsistent decision making) ▪ Level 3 Linking a defined set of rules into business processes or using applications executed with a Basic Rules Management System (often called a Rules Engine)	
IME Technical Function Description	
The components of Iowa's MMIS are not rules based.	
IME As-Is Maturity Level	Level 1
Primarily Iowa applies its Medicaid rules using manual processes which meet level 1 for this function.	

F.2 – Extensibility

MITA Technical Function Description and Capabilities

Extensibility technical area is focused on the ability of the State to apply extensions to system functionality.

- Level 1 Extensions to system functionality that require pervasive coding changes
- Level 3 Services with points at which to add extensions to existing functionality (changes highly localized)

IME Technical Function Description

Iowa is making strides in introducing modularity in the non-legacy portions of the MMIS, but the majority of the MMIS still require a high degree of pervasive coding changes.

IME As-Is Maturity Level	Level 1

Iowa meets level 1 for this function because of the modularity implemented in their MMIS and auxiliary systems as a composite is low.

F.3 – Automate Configuration and Reconfiguration Services

MITA Technical Function Description and Capabilities

Automate configuration and reconfiguration services technical area is focused on the State's approach to configuration management.

- Level 1 Configuration and reconfiguration of distributed application that typically requires extensive hard-coded changes across many software components and/or applications across the enterprise (and with significant disruption)
- Level 4 Consistent distributed applications using common business change processes that coordinate between active components and ensure minimal disruption
- Level 5 Consistent distributed applications using common business change processes that coordinate between active components and ensure minimal disruption

IME Technical Function Description

Iowa currently uses CA Panvalet as one element for versioning and software and data control for the legacy portion of the MMIS. Iowa does support automated configuration and reconfiguration services that require mostly extensive hard-coded changes across many software components. In general, the published procedures and configuration management plan is applied inconsistently across various systems.

The Iowa MMIS legacy system is a COBOL/VSAM system and is not considered a distributed application.

Some components of the Medicaid Enterprise Environment are developed and maintained in a Client-Server structure. The configuration and reconfiguration typically requires extensive hard-coded changes.

IME As-Is Maturity Level	Level 1

Iowa fully meets level 1 for this function. While the Data Warehouse approaches level 2, the legacy MMIS is not a distributed application and the configuration management process in Iowa is ad-hoc.

F.4 – Introduction of New Technology	
MITA Technical Function Description and Capabilities	
Introduction of new technology technical area is focused on the State's ability to introduce new technology and the affect that has on existing systems. ▪ Level 1 Technology-dependent interfaces to applications that can be significantly affected by the introduction of new technology ▪ Level 3 Technology-neutral interfaces that localize and minimize the impact of the introduction of new technology (e.g., data abstraction in data management services to provide product neutral access to data based on metadata definitions)	
IME Technical Function Description	
For the most part, the legacy MMIS has technology-dependent interfaces that can be significantly affected by the introduction of new technology.	
IME As-Is Maturity Level	Level 2
Iowa fully meets level 1 for this function because the legacy MMIS uses technology-dependent interfaces but is moving towards level 2 with the newer technology.	

3.3 General Observations from the As-Is Assessment

As IME stands today, it is unusually well positioned to move forward along the MITA Maturity Model. The IME approach of selecting the "best of breed" vendor to support its business functions allows IME to take advantage of a modular approach that will facilitate an evolution towards the Service Oriented Architecture at the root of the MITA Framework. Additionally, IME understands the importance of looking to the business needs of the organization to define the processes, procedures, and tools to support these needs.

The organizational concept behind IME has been found to be effective, supporting all business areas well. The close collaboration among the IME state staff and the vendors supported by open communication has served IME well. All of this has served to minimize duplication of activities across the division and facilitate coordination across business areas and programs. At the same time, it was acknowledged by the assessment session participants, that there are many opportunities for improvement in areas such as consistency in communications, workflow management, reduction in the use of paper, access to data, and automation of processes.

Many of these points of opportunity to improve processes are reflected in the To-Be Maturity Level goals set by the IME Planning Committee. Section 4.2.1 Business Process As-Is and To-Be Maturity Levels displays these goals in a table that shows the As-Is Maturity Level against the To-Be goals.

4.0 IME Priorities and the MITA To-Be Vision

4.1 Context: The MITA Enterprise, IME Vision and Priorities, State and National Trends

In order for a MITA State Self-Assessment to accurately represent the realities of a State's Medicaid Program, the context within which the program functions must be taken into account. This context is both State-specific and national and, under the MITA, has a slightly different outline. This section addresses contextual realities for IME.

4.1.1 The Iowa MITA Enterprise

What has been understood to be included in a Medicaid enterprise by most States is not as broad as the definition of the Medicaid enterprise found in the MITA Framework. The following illustration demonstrates that this situation is true for Iowa. The red oval in the figure, the Iowa MITA Enterprise, is used to distinguish it from the IME.

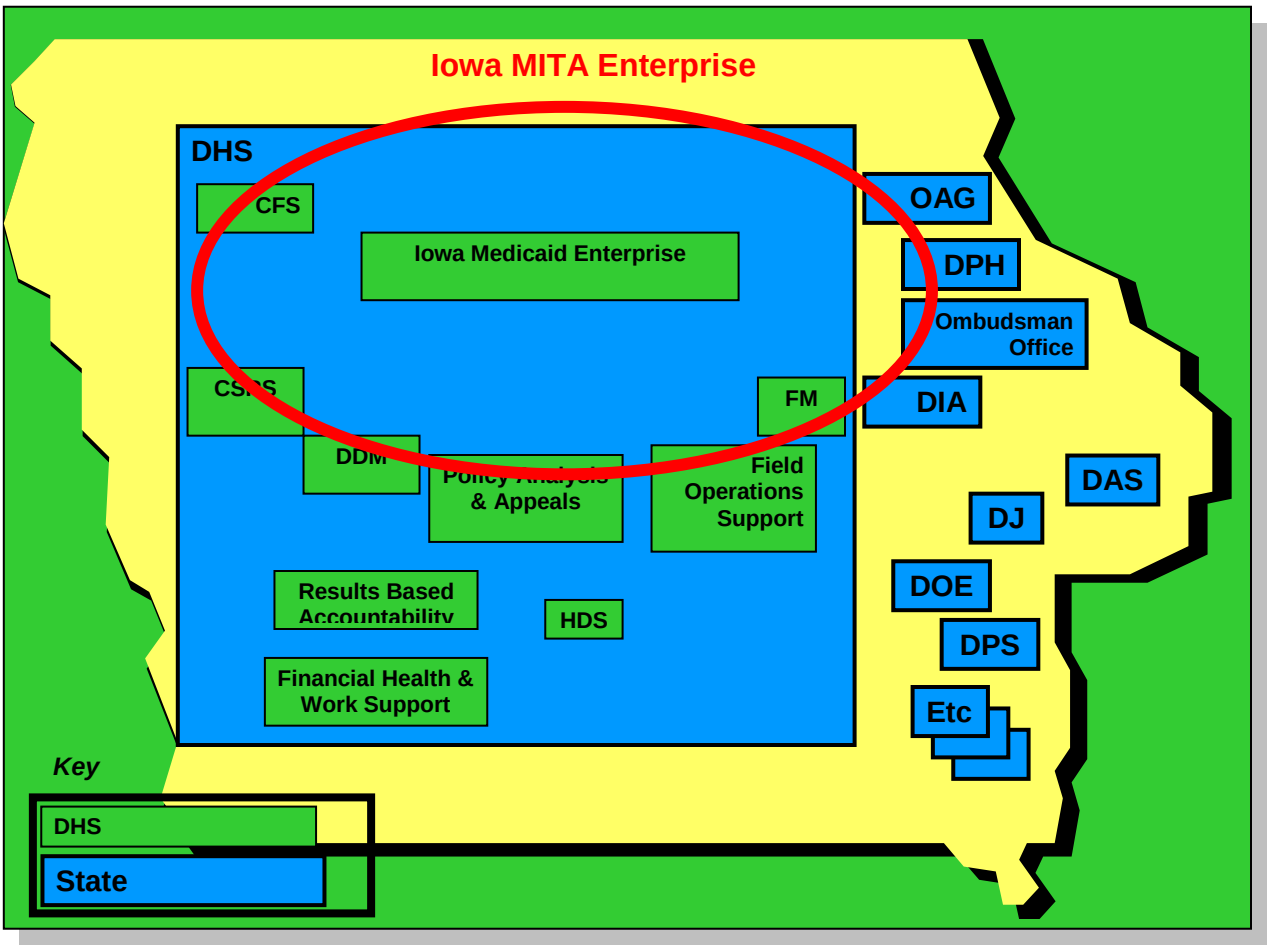

Figure 3 IME MITA Enterprise

While the IME includes most of the Business Processes included in the MITA Business Architecture, some processes and/or portions of processes are the responsibility of areas outside of IME. For example, many of the activities related to the management of IME funds are the responsibility of DHS Fiscal Management (FM). Note: In the diagram, the box representing FM is shown with the red oval representing the Iowa MITA Enterprise running through the box. This signifies that some (but not all) of FM's responsibilities support Iowa MITA Enterprise functions.

One of the expectations of the MITA Framework is that, as an organization moves along the MITA Maturity Model, interagency (or in the case of Iowa, interdivision and departmental) coordination increases. In order for Iowa to move towards compliance with Level 3 of the MITA Maturity Model, the MITA standards (as they become available) must be adopted, not only by IME, but by the other divisions or departments that share responsibility for the business processes defined as part of the MITA Enterprise. These standards are not being developed in a

vacuum. Industry standards for a given process are part of the information included in the development of the MITA standard for that process.

4.1.2 Vision and Priorities

One of the key elements of MITA is the consideration during the assessment of the vision and mission for the Medicaid Program and the priorities set by the program's management. The Iowa Department of Human Services has defined the following Vision and Mission.

Vision

The Iowa Department of Human Services makes a positive difference in the lives of Iowans we serve through effective and efficient leadership, excellence, and teamwork.

Mission

The Mission of the Iowa Department of Human Services is to help individuals and families achieve safe, stable, self-sufficient, and healthy lives, thereby contributing to the economic growth of the state. We do this by keeping a customer focus, striving for excellence, sound stewardship of state resources, maximizing the use of federal funding, leveraging opportunities, and by working with our public and private partners to achieve results.

Priorities

The IME Planning Team held two Executive Visioning Session facilitated by FOX: one on December 9, 2008, and the other on April 7, 2009. The purpose of these sessions was to identify the priorities that would support To-Be goal setting.

In the December session, IME's Planning Committee identified the following Medicaid Director priorities, listed in no particular order:

- Expanding coverage
- Broader focus on eligibility
- Improving quality

At the same meeting, the following Federal requirements and IME initiatives that will need to be implemented or completed over the next 5 to 10 years were identified:

- 5010
- ICD-10
- Electronic claim attachments
- Medicaid subrogation for Pharmacy claims
  - NCPDP standard transaction

- PASSAR
- PERM
- MIG
- Correct Coding Initiative (CCI)
- Medicaid Value Management (MVM)

The following priorities are drawn from the items discussed at both the December and April meetings. These priorities are listed in no particular order, but are grouped into short-term (regarding upcoming procurements) and long-term (over the next 5-10 years) priorities.

- Short Term Priorities
  - Improved Web-based options for Providers
  - Credentialing utilizing a credentialing clearinghouse
  - Implement processes focused on contract performance (MAGIC Unit, review of contract performance measures)
  - Implement processes focused on strategic management (both of contracts and state staff)
  - Training unit for State staff, program and data analysis focus
  - Implement processes focused on value management (MVM)
  - Improve data analysis capabilities
    - Access (new Memorandum Of Understanding (MOU) for data warehouse, population health information)
    - Tools (data mining, analytics, predictive modeling, new MOU for data warehouse)
  - Improve Member Services
    - Expand member education
    - Establish medical home
    - Implement an Ask-a-Nurse Network
    - Establish a Protocol related Member Eligibility
  - Modular approach to replacing system functionality
  - Expansion of document management and workflow management capabilities (OnBase)
- Long-Term Priorities
  - Improving the safety and quality of waiver programs, including aggregating waiver services data
  - Data analysis to be a key component of every operational unit
    - Imbed more expertise in the units, e.g., each unit would have their own business analyst (vendor provided)
    - Access to better analyze data
  - Implement a rules-based engine to allow the policy unit to change the rules
  - Automated verification (licensing board, background checks for providers)

- Improved web-based options for Members and Providers
- Credentialed as a Managed Care Organization (MCO)
- Expanding Care Management beyond the current set of programs
- Self-audit process for Program Integrity
- Program Integrity component for each unit, embedded in unit operations
- Shift the focus of the Policy Unit from handling exceptions to defining business rules
- Ongoing evaluation of prior authorizations

The Table 5 Alignment of IME Priorities with MITA Goals in Section 1.4.1 of the Executive Summary was produced by aligning the above priorities with the goals and objectives as defined in the MITA Framework 2.0. The table holds a condensed version of these goals and objectives. The complete statements are offered here:

1. Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards
2. Promote an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology
3. Promote an enterprise view that supports enabling technologies that are aligned with Medicaid business processes and technologies
4. Provide data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for health care management and program administration
5. Provide performance measurement for accountability and planning
6. Coordinate with public health and other partners, and integrate health outcomes within the Medicaid community

4.1.3 State and National Trends

Today, more than ever before, organizations in the health care industry are pressured from many sides to improve technology, reduce costs, extend service, and create a patient-centric environment for Program participants. Many of these initiatives bring additional pressure to bear on the Medicaid agency and are also factors in determining the strategic direction in the MITA To-Be phase. Several of these initiatives are described below:

- *American Recovery and Reinvestment Act of 2009 (ARRA)*: Stimulus funding opportunities and associated requirements and deadlines are the latest package of initiatives to hit State Medicaid agencies. Each State is asked to apply for Planning and Implementation grant money to establish an HIE capability to interface with providers (not just Medicaid) and facilitate the exchange of clinical information and facilitate "Meaningful Use" of the providers' data. Each State also must establish a mechanism for certifying Meaningful Use compliance and distributing funds to the compliant providers. The role Medicaid will play in

this new activity is not yet clear. Each State is responsible for establishing its role and obtaining the Stimulus grant and/or matching funds.

- *Medicaid Transformation Grants (MTG):* Many States applied for MTGs to support development of pilot health information exchange (HIE) models. In States where the MTG has resulted in an operational HIE, there will be some demand on the MMIS to facilitate the exchange of electronic clinical information.
- *Electronic Medical Records (EMR):* The Electronic Medical Record Advisory groups are moving toward the development of a standard electronic medical record architecture and processing model. There may be implications in these proposed structures for the data that will be required by an MMIS particularly as MMIS systems participate in Health Information Exchanges (HIE). Health Level 7 (HL7) has already developed standards for data contained within an electronic health record and these are in use through the Certification Commission for Healthcare Information Technology (CCHIT) initiative for the certification of Electronic Health Record (EHR) software products. Currently, electronic clinical data is not being received by State Medicaid agencies. MITA Level 4 business process capabilities require use of clinical data.
- *Health Insurance Portability and Accountability Act (HIPAA)*: Many health care organizations have yet to implement all the requirements from the original HIPAA rules. Additionally, the two new HIPAA Modification Rules require the promulgation of several more regulatory mandates in the next few years, including additional or updated Privacy and Security requirements, as well as updates and new initiatives within the Transactions and Code Sets compliance requirements. The first Rule requires adoption of significant changes to transactions including X12 (ASC X12) Version 5010 and (NCPDP) Version D.0. Also included in the rule is a new standard for Medicaid subrogation for pharmacy claims, known as NCPDP Version 3.0. The compliance date for all covered entities is January 1, 2012, except for small health plans which have until January 1, 2013. The second Rule requires adoption of the ICD-10 by October 1, 2013 for all covered entities.
- *Managed Care Expansion:* Many States have implemented managed care alternatives and at any one time, a State may be considering implementing, expanding, constraining, or changing managed care programs. These initiatives and changes always impact the MMIS.
- *Medicare Modernization Act (MMA):* This legislation provides prescription drug benefits to seniors and people with disabilities under Medicare. It is likely that this program will evolve over the next few years and could impact MMIS requirements.
- *Nursing Home Quality of Care:* Quality of care in nursing home is a perennial issue and one that is gaining increased attention.
- *Health Outcomes Data Access*: Access to the extensive health process data that implicitly resides in MMIS systems is being increasingly sought by researchers and oversight agencies.
- *Budget Initiatives*: The structure of the economic recovery and the necessity to decrease the deficit will place pressure on funding for public health insurance programs for some time to come. Changing population demographic will add to that pressure.
- *MITA Alignment and Updates to the MITA Framework 2.0*: Including updates from Framework Version 2.01 released in July 2008.

- *Additional State and Federal Legislative Initiatives*

4.2 Observations

4.2.1 Business Process As-Is and To-Be Maturity Levels

The following table summarizes the assessed As-Is and To-Be Maturity Levels for the Iowa Business Processes. The To-Be Maturity Levels were determined by the IME Planning Committee. It includes comments that address what capabilities are needed to achieve the specified To-Be level. At the time the SS-A was performed, updates to the Framework 2.0 capabilities had not been released by CMS. For many of the processes, while FOX utilized a set of capabilities based on our understanding of MITA capabilities in general, specific capabilities in Framework 2.0 were yet to be developed, were lacking in specificity to the process, or were limited in scope. (Note the processes with a double asterisk in the To-Be Level column). These factors should be taken into account when setting priorities for the short-term. CMS is in the process of releasing revised capabilities. As they become available, FOX recommends that IME review these revised capabilities to add this information regarding the direction in which CMS is moving to the pool of data under consideration as part of IME's decisions. The revised capabilities will be utilized when FOX performs the update to the SS-A in a later phase of the project.

CMS recognizes that an organization cannot move to a SOA environment in one step. As mentioned in section 3.3, above, IME's intent to take a modular approach in implementing organizational and system changes supports the transition to SOA. IME, in setting it's priorities, will need to determine for each iteration of improvements over the course of the next 5 to 10 years, which processes will be implemented within a SOA environment and which will have to wait until the next iteration of improvements. In the course of the SS-A, only one process was identified as being implemented as a service (OM03). For this reason, in the To-Be Comments column of this table, two alternate phrases have been offered and highlighted in Aqua for those processes that have a To-Be level of 3: one, to use if the decision is taken to implement SOA in relation to the business process, the other, to use if the decision is taken not to do so.

Table 11 Business Processes As-Is and To-Be Maturity Levels

Note: Level 3, as defined in the MITA Framework, implies that implementation of MITA standards and implementation within a SOA environment will be part of the To-Be enhancements. At the time this report was completed, no MTIA standards for any process had been defined.

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
	Member Management			
ME01	Determine Eligibility	2	3	The Long Term To-Be goal is to go as

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented.** To do this data standards across platforms and interfaces must be implemented; electronic mechanisms for communication (both internal to IME and external) must become the norm; automation of most process steps, to include rules-driven, uniform decision making and all verifications, must be implemented in such a manner that decisions can be immediate and the results immediately available to stakeholders and succeeding processes; and choices among services and provider types available within funding limits of all benefit packages for which the member is eligible must be offered to members.
ME02	Enroll Member	1	2	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces; movement towards a more uniform process (common forms, single role based interface) process that can follow immediately after eligibility determination; implementation of electronic mechanisms for communication (both internal to IME and external) and increased automation process steps including the use of automated business rules, the ability to submit applications on line and via other electronic mechanisms, the increased ability to blend benefits to meet health needs, and the collection of data (provider and member) to facilitate meeting member linguistic and cultural needs.
ME03	Disenroll Member	1	2**	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces; increased automation of process steps.

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
ME04	Inquire Member Eligibility	1	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this data standards across platforms and interfaces must be implemented and managed via a central data store or federated data stores that continually refresh the member data; the process must be automated and capable of providing immediate responses, incorporating electronic mechanisms for communication (both internal to IME and external); and responses must address both eligibility and benefits.
ME05	Manage Applicant and Member Communication	1	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this (MITA when available) data standards across platforms and interfaces must be implemented both within IME and among collaborating agencies to provide a single view of the data that can be immediately available; the process must be coordinated across the agency and among collaborating agencies to provide a one-stop shop for member inquiries (e.g. same answers whether the contact comes in at IME or some other spot within DHS); electronic mechanisms for communication (both internal to IME and external (e.g. increased use of web based mechanisms or low cost telecommunication devices and centralized, electronic storage of communications) must become the norm, with paper used only as an exception; automation of most process steps must take place; and

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				linguistic, cultural, and competency factors must be incorporated into responses.
ME06	Manage Member Grievance and Appeal	1	2	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces; continued movement towards a more centralized (or at least centrally managed) process in relation to complaints and grievances; improvement and expansion of electronic mechanisms for communication (both internal to IME and external); and automation of some process steps. (Potential for level 3, see Manage Provider Grievance and Appeals)
ME07	Manage Member Information	1	2	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces; movement towards a more centralized (or at least centrally managed) process; full automation of updates; implementation of rule-based edits/validation/data reconciliation; full standardization among all systems that includes day based eligibility/enrollment.
ME08	Perform Population and Member Outreach	1	2	The To-Be goal is Level 2 through movement towards a more centrally managed process; implementation of electronic mechanisms for communication (both internal to IME and external, e.g. increased use of web based mechanisms and centralized, electronic storage of outreach materials); automation of more process steps to include monitoring of web site usage so members not accessing information can be reached by other means; and increased incorporation of functional, cultural and competency factors into the design of outreach. Use of web site not monitored.
	Provider Management			

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
PM01	Enroll Provider	1	2	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces; improvements in automation of process steps; the collection of information that facilitates matching providers to patient needs; and the definition of guidelines to ensure the adequacy of provider networks for all programs. IME short term goals include a number of items that are characteristic of level 3 (e.g., web based support for providers-enrollment applications, use of a credentialing clearing house) and will position IME to meet level 3 capabilities over the next 5-10 years.
PM02	Disenroll Provider	1	3**	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this the process must be automated to the point where manual processing is the exception; common data interfaces must be implemented between IME and other agencies.
PM03	Inquire Provider Information	1	2	The To-Be goal is Level 2 through movement towards a more centralized (or at least centrally managed) process; and increased automation of process steps.
PM04	Manage Provider Communication	1	2	The To-Be goal is Level 2 through movement towards a more centrally consistent process; implementation of electronic mechanisms for communication (both internal to IME and external) and automation of some process steps to include documentation of all calls in a centrally accessible data store. IME short term goals include some of items that are characteristic of level 3 (e.g., web based support for providers) and will position IME to meet level 3

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				capabilities over the next 5-10 years.
PM05	Manage Provider Grievance and Appeal	1	2	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces; movement towards a more centralized (or at least centrally managed-complaints/grievances) process; implementation of electronic mechanisms for communication (both internal to IME and external), and automation of some process steps. IME short term goals include some of items that are characteristic of level 3 (e.g., web based support for providers) and will position IME to meet level 3 capabilities over the next 5-10 years.
PM06	Manage Provider Information	1	2	The To-Be goal is Level 2 through movement towards a more centralized (or at least centrally managed) process in terms of data; implementation of electronic mechanisms for communication (both internal to IME and external); collection of cultural and linguistic information fro all providers; and increased automation of process steps.
PM07	Perform Provider Outreach	1	2	The To-Be goal is Level 2 through continued improvements in electronic mechanisms for communication (both internal to IME and external); continued outreach to providers to encourage use of these mechanisms (including monitoring use of the web site to allow for targeted encouragement); and increased automation of process steps. IME short term goals include some of items that are characteristic of level 3 (e.g., web based support for provider training) and will position IME to meet level 3 capabilities over the next 5-10 years.
	Contractor Management			
CO01	Produce Administrative or Health Services RFP	1	2**	The To-Be goal is Level 2 through implementation of electronic mechanisms for communication (both internal to IME and external); and

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				automation of some process steps.
CO02	Award Administrative and Health Services Contract	1	2**	The To-Be goal is Level 2 through implementation of electronic mechanisms for communication (both internal to IME and external) such as submission of proposals via a portal; and increased automation of process steps.
CO03	Manage Administrative and Health Services Contract	1	2**	The To-Be goal is Level 2 through implementation of electronic mechanisms for communication (both internal to IME and external); and increased automation of process steps (plans are to include automation of performance measures).
CO04	Close-out Administrative and Health Services	1	2	The To-Be goal is Level 2 through implementation of electronic mechanisms for communication (both internal to IME and external); and increased automation of process steps, clearly defined protocol
CO05	Manage Contractor Information	1	2	The To-Be goal is Level 2 through and increased automation of process steps and centralization or federation of contractor data so that information can be immediately available and requests can be standardized.
CO06	Manage Contractor Communication	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this the established centralized process must be followed; electronic mechanisms for communication (both internal to IME and external) must become the norm; storage of contractor data must be centralized or federated; and automation of most process steps must take place.
CO07	Perform Contractor Outreach	1	2	The To-Be goal is Level 2 through use of new mechanisms for outreach to include TV, radio, or advertisements; incorporation into performance measures of the clinical and

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				administrative indicators of populations needed to target outreach to contractors to ensure population health and access.
CO08	Support Contractor Grievance and Appeal	1	2	The To-Be goal is Level 2 through implementation of electronic mechanisms for communication (both internal to IME and external) and automation of most process steps.
CO09	Inquire Contractor Information	1	2**	The To-Be goal is Level 2 through implementation of electronic mechanisms for communication (both internal to IME and external); greater central coordination of the process and data; and increased automation of process steps.
	Operations Management			
OM01	Authorize Referral	1	2	The To-Be goal is Level 2 through implementation of electronic mechanisms for communication (both internal to IME and external) including use of the web site; automation of some process steps; and increased outreach to providers to encourage use of the HIPAA transactions.
OM02	Authorize Service	1	2	The To-Be goal is Level 2 (short-term) through outreach to encourage the use of EDI and improve the processes ease-of use for providers. Level 3 (long-term)
OM03	Authorize Treatment Plan	2	3	The To-Be goal is Level 3 through implementation of the process as a service and of MITA standards when they become available. **This process has been identified as one for which SOA will be implemented**.
OM04	Apply Claim Attachment	1	2	The To-Be goal is Level 2 through the implementation of electronic attachments, once HIPAA standards are finalized.
OM05	Apply Mass Adjustment	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this,

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				improvements in the flexibility to easily change the criteria for identifying claims and applying the adjustment must be made.
OM06	Edit Claims-Encounter	1	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this the following is needed: paper claims and manual processing will be the exception; a single system processes all claims; implementation of MITA standards for interfaces, Implementation Guides, and data so that claims/encounters no longer require translation; a system that can support accurate, real time processing, easily maintained code sets and rules engines, complex benefit package algorithms, encounters submitted as HIPAA compliant COB claims, and flagging of claims for payer-to-payer COB in an environment where related processes are decoupled. *Note: The centralization of this process was only referenced in the capabilities at Level 2 and only in relation to waiver claims. Additionally, point of sale (POS) or web-based processing is explicitly referenced in the description as not applying to a stand-alone Edit Claim/Encounter process. However, the MITA maturity scale points towards integrating processes for all claims to the greatest extent possible. Supporting separate systems without clearly functional differentiation is unlikely to be supported as meeting Level 3 capabilities. In the future, if all claims are being processed in a similar manner (e.g., point-of-sale environment) the question of why you would support separate POS systems arises. Consider also the additional*

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				fact that non-emergency medical transportation claims are currently processed outside of IME. Before settling on level 3 as your short-term goal, FOX recommends review of the capabilities in the 2.01 BCM updates for both the Edit and Audit processes.
OM07	Audit Claim	1	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this the following is needed: paper claims and manual processing will be the exception; a single system processes all claims; implementation of MITA standards for interfaces, Implementation Guides, and data so that claims/encounters no longer require translation; a system that can support accurate, real time processing, easily maintained code sets and rules engines, complex benefit package algorithms, encounters submitted as HIPAA compliant COB claims, and flagging of claims for payer-to-payer COB in an environment where related processes are decoupled. *Note: The centralization of this process was only referenced in the capabilities at Level 2 and only in relation to waiver claims. Additionally, point of sale (POS) or web-based processing is explicitly referenced in the description as not applying to a stand-alone Edit Claim/Encounter process. However, the MITA maturity scale points towards integrating processes for all claims to the greatest extent possible. Supporting separate systems without clearly functional differentiation is unlikely to be supported as meeting Level 3 capabilities. In the future, if all claims are being processed in a similar manner (e.g., point-of-sale*

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				environment) the question of why you would support separate POS systems arises. Consider also the additional fact that non-emergency medical transportation claims are currently processed outside of IME. Before settling on level 3 as your short-term goal, FOX recommends review of the capabilities in the 2.01 BCM updates for both the Edit and Audit processes.
OM08	Price Claim-Value Encounter	1	2	The To-Be goal is Level 2 (short-term) through automation of most single claim adjustments. Level 3 (long-term)
OM09	Prepare Remittance Advice-Encounter Report	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented.** To do this production of paper RAs must become the exception and all electronic billers must receive electronic RAs. *Note: Currently, in IME there is no distinction between HCBS payment reports and RAs. Capabilities for both this process and the Prepare Home and Community Based Services Payment need to be taken into account when determining To-Be goals.*
OM10	Prepare Provider EFT-check	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented.** To do this production of paper checks must become the exception and all electronic billers must receive EFT via a process common to multiple State agencies.
OM11	Prepare COB	N/A		This process is not currently carried out by IME.
OM12	Prepare EOB	1	2	The To-Be goal is Level 2 through the implementation of a mechanism that can produce both a true random

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				sample and be configured to target selected populations and the introduction of cultural and linguistic adaptations. *Note: IA state law specifies English as the language and limits the emphasis on incorporating linguistic factors into EOMBs*
OM13	Prepare Home and Community Based Services Payment	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this IME and sister agencies must agree to use MITA standard interfaces for payment transactions. *Note: Currently, in IME there is no distinction between HCBS payment reports and RAs. Capabilities for both this process and the Prepare Remittance Advice need to be taken into account when determining To-Be goals.*
OM14	Prepare Premium EFT-check	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this production of paper checks must become the exception and all electronic billers must receive EFT via a process common to multiple State agencies.
OM15	Prepare Capitation Premium Payment	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this, IME will automate more of the current process and implement MTIA standards when they become available. (Note: the only capability documented in the 2.0 version of the BCM that IME does not

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				currently meet relates to MTIA standards.)
OM16	Prepare Health Insurance Premium Payment	1	1	The To-Be maturity level will remain at level 1. Most payments are made to the Member or the employer. Payments to insurance companies are so infrequent that implementation of the HIPAA premium payment transaction for HIPP payments is not cost effective under the current program realities. Use of the EFT process may be considered for the future.
OM17	Prepare Medicare Premium Payment	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this, IME will automate more of the current process and implement MITA standards when they become available. (Note: the only capabilities documented in the 2.0 version of the BCM that IME does not currently meet relate to MITA standards.)
OM18	Inquire Payment Status	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this the process must be more completely automated, and made available 24x7. Time lags and disconnects between systems must be resolved and providers encouraged to utilize either web based or transaction-based mechanism for inquiry.
OM19	Manage Payment Information	1	2	The To-Be goal is Level 2 through increased standardization of data and a more centralized (or federated) process and data store; and implementation of analysis tools for use with the Payment Information data store.

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
OM20	Calculate Spend-Down Amount	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this the process must eliminate the need for members to report their costs to the extent feasible and implement a deductible as a spend-down mechanism.
OM21	Prepare Member Premium Invoice	1	2	The To-Be goal is Level 2 (short-term) through the addition of hearing rights to the member premium notifications. Level 3 (long-term)
OM22	Manage Drug Rebate	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this, IME will automate more of the current process and implement MITA standards when they become available. (Note: the only capabilities documented in the 2.0 version of the BCM that IME does not currently meet relate to MITA standards.)
OM23	Manage Estate Recovery	1	2	The To-Be goal is Level 2 (short-term) through automation of some process steps.
OM24	Manage Recoupment	1	2	The To-Be goal is Level 2 (short-term) through automation of some (specifically related to SURS activities) process steps and increased use of EDI that.
OM25	Manage Cost Settlement	1	2	The To-Be goal is Level 2 through introduction of EDI as a mechanism for communicating with providers.
OM26	Manage TPL Recovery	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this, IME will

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				automate more of the current process and implement MITA standards when they become available. (Note: the only capability documented in the 2.0 version of the BCM that IME does not currently meet relates to MITA standards.)
	Program Management			
PG01	Designate Approved Service/Drug List	1	2	The short term To-Be goal is level 2 through movement towards a more centralized (or at least centrally managed) process and automation of process steps. Long-term, the goal is to move to level 3.
PG02	Develop and Maintain Benefit Package	2	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented.** To do this Improvements in (system) flexibility in relation to the implementation of benefit package changes and the ability to blend benefits are needed as is the introduction of clinical data to the benefit development process.
PG03	Manage Rate Setting	1	2**	The To-Be goal is level 2 through increasing automation of the process, and introducing data standards for systems and/or interfaces.
PG04	Develop Agency Goals and Objectives	1	2**	The To-Be goal is Level 2. A formal, centrally coordinated process is needed along with improvements in workflow management and communication mechanisms to introduce automation to this process.
PG05	Develop and Maintain Program Policy	1	3**	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA.** Improvements in workflow management and communication mechanisms are needed to automate this process to the extent feasible
PG06	Maintain State Plan	1	3**	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				without MITA standards having been defined **and without implementing SOA.** Improvements in workflow management and communication mechanisms are needed to automate this process to the extent feasible.
PG07	Formulate Budget	1	2**	The To-Be goal is Level 2 through implementation of internal data standards across platforms and improvements in workflow management and communication mechanisms to increase coordination and transparency and.
PG08	Manage FFP for MMIS	1	2	The To-Be goal is Level 2 (short-term). Improvements in implementation of internal data standards across platforms are needed to improve accuracy and timeliness and to allow for increased automation. The Long-term goal is Level 3
PG09	Manage F-Map	1	2**	The To-Be goal is Level 2 (short-term) through the Implementation of internal data standards across platforms. The long-term goal is Level 3
PG10	Manage State Funds	1	2	The To-Be goal is Level 2 (short term). Improvements in workflow management and communication mechanisms are needed to increase coordination and process automation and also needed is implementation of internal data standards across platforms. The long-term goal is Level 3
PG11	Manage 1099s	1	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this electronic access for providers (web based) to 1099 information and submission of 1099 related requests would need to be implemented along with automation of the process to the extent feasible.

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
PG12	Generate Financial and Program Analysis Report	1	2	The To-Be goal is Level 2 through the implementation of internal data standards and interfaces, at least, within IME. Also needed is increased automation of the process (e.g., implementation of electronic tracking of ad-hoc requests to enable the re-use of previously defined queries).
PG13	Maintain Benefits-Reference Information	1	3	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented.** To do this, the process must be automated to the extent feasible, and the various pieces of the "Benefit/Reference data store must be been unified in a single source or configured as a federated collection of data stores.
PG14	Manage Program Information	1	2**	Remain at level 2 (short-term). Level 3 (long-term)
PG15	Perform Accounting Functions	1	2**	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces; movement towards a more centralized (or at least centrally managed) process; and increased automation of process steps.
PG16	Develop and Manage Performance Measures and Reporting	1	2**	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces and automation of at least some process steps.
PG17	Monitor Performance and Business Activity	1	2**	The To-Be goal is Level 2 through implementation of data standards across platforms and interfaces; and improvements in automation of process steps.
PG18	Draw and Report FFP	1	2**	The To-Be goal is Level 2 (short-term) through implementation of data standards across platforms and interfaces, improvements in cost management and quality assurance, and improvements in automation of process steps.

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				The long-term goal is Level 3
PG19	Manage FFP for Services	1	2**	The To-Be goal is Level 2 (short-term) through implementation of data standards across platforms and interfaces, improvements in cost management and quality assurance, and improvements in automation of process steps. The Long-term goal is Level 3
PGIA01	Manage Legislative Communication	2	2	The To-Be goal is to remain at Level 2. The process is not defined by IME so the division's ability to improve the process is potentially limited. Increased automation and a centralized database of legislative communications within IME are possible improvements. The long-term goal is Level 3 through development of a state-specific SOA solution.
	Business Relationship Management			
BR01	Establish Business Relationship	1	2**	The To-Be goal is Level 2 through automation of process steps to include the implementation of electronic mechanisms for communication (both internal to IME and external).
BR02	Manage Business Relationship	1	2**	The To-Be goal is Level 2 through automation of process steps to include the implementation of electronic mechanisms for communication (both internal to IME and external).
BR03	Terminate Business Relationship	1	2**	The To-Be goal is Level 2 through automation of process steps to include the implementation of electronic mechanisms for communication (both internal to IME and external).
BR04	Manage Business Relationship Communications	1	2**	The To-Be goal is Level 2 through automation of process steps to include the implementation of electronic mechanisms for communication (both internal to IME and external).
	Program Integrity Management			
PI01	Identify Candidate Case	2	3**	The To-Be goal is Level Note: Implementation of data standards across all platforms and

Business Processes		Maturity		
#	Name	As-Is	To-Be	To-Be Comments
				interfaces and implementation of electronic mechanisms for communication (both internal to IME and external) will improve the ability to identify candidate cases and alert the appropriate individuals or units.
PI02	Manage Program Integrity Case	1	2**	The To-Be goal is Level 2 through implementation of electronic mechanisms for communication (both internal to IME and external); automation of some process steps;
	Care Management			
CM01	Establish Case	2	3**	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this the process must be automated.
CM02	Manage Care Management Case	2	3**	The To-Be goal is to go as far toward meeting Level 3 capabilities as possible without MITA standards having been defined **and without implementing SOA. This process has been identified as one for which SOA will be implemented**. To do this the process must be automated.
CM03	Manage Medicaid Population Health	1	2**	The To-Be goal is Level 2 through increased use of electronic mechanisms to automate process steps (data analysis).
CM04	Manage Registry	N/A		This process is not currently conducted by IME. All known health related registries are maintained outside of the IME.

4.2.2 Strategies for Prioritizing MITA To-Be Goals

There are several directions from which to approach the prioritization of To-Be goals under MITA:

- Business Area/Business Process Strategies
  - Center around improving the capabilities of a Business Area or process
  - May address specific stakeholder constituency needs
  - May include benefit to other business area/process
- Crosscutting Strategies
  - Address agency *business* needs that affect more than one Business Area or process. Several of the 8 major MITA Business Areas have similar functions, particularly in the Business Processes of information management, communication and grievance.
  - Can involve improving the capabilities of a technical area or function to support the business needs
- A blending of the two approaches
  - Some priorities address improvements to Business Areas or Business Processes
  - Some address business needs or capabilities that affect more than one Business Area or process

FOX recommends that a State take the third approach and look at their priorities from both an individual business area/business process perspective and a crosscutting perspective. In setting the priorities documented in section 4.1.2 Vision and Priorities, IME has done exactly this. For example, expanding member education is a process-specific priority (ME08 Perform Population and Member Outreach). The expansion of document management and workflow management capabilities, on the other hand, impacts all Business Areas to one degree or another.

During the course of the Business Assessment, FOX noted a number of emerging themes among the items documented under the headings of what was working, what was not working, and under the more informal To-Be discussion. Many of these items have already been noted in the priorities from the Executive Visioning session. The list, below, includes additional or more general items that came out of the Business Process assessment sessions.

1. The IME organizational concept supports the functioning of business processes.
2. The IME model has encouraged close collaboration and communication between State staff and Vendor staff.
3. In the future there is a need for increased emphasis on automating tasks where business needs allow:
   a. Replacing use of checks with EFT
   b. Imaging to eliminate/reduce paper
4. In the future there is a need for increased emphasis on centralizing common processes or the management/oversight of common processes.

5. In the future there is a need for increased emphasis interagency (inter division/department) collaboration for processes involving shared responsibility, especially in regards to systems and policy.
6. In the future there is a need for improvements in communication are needed:
    a. Increased use of electronic mechanisms
    b. Centrally available tracking of communications (member, provider, contractor, legislature)
    c. Clearly defined Communication Plan, including governance (especially regarding interagency communications)
7. In the future there is a need for implementation of unified interfaces or single points of entry for a specific process or functionality where multiple systems are involved (including a universal log-in).
8. In the future there is a need for increased system integration including:
    a. Iowa MITA Enterprise-wide data standards and interface standards
    b. Real-time bidirectional availability of data between systems
9. In the future there is a need for improved data management to include:
    a. Enterprise-wide consistent data and interface standards
    b. Central repositories for information used by multiple units (e.g., contract management information, business relationship agreements, etc.)
    c. Centralization or federation of data stores currently supported by multiple systems
10. In the future there is a need for consistency of privacy and security policy across all applications

Many of the items noted in the above list relates to opportunities for improvement that, if not addressed, will continue to have a negative impact on the effectiveness and efficiency of the Medicaid Program in Iowa. Most of these items are crosscutting and will impact multiple business areas and processes. By prioritizing items such as these, IME can maximize the impact of its investment in both effort and resources.

4.3 IME – The Future

4.3.1 Transitioning Forward with MITA

Evolutionary transition planning is an iterative process that is focused on the delivery of value to each Medicaid stakeholder. Iterative transition planning steps should provide the common answers for those and other simple questions that are part of every State's transition planning:

- Is it of value?
- Can we support it technically?
- Does our Governance Structure allow us to?
- What are our priorities?
- What have been our successes/where are our strengths?

Figure 4 Transition Planning Phases is CMS' vision for the transitioning process. This iterative process can and must be tailored to fit each State's needs.

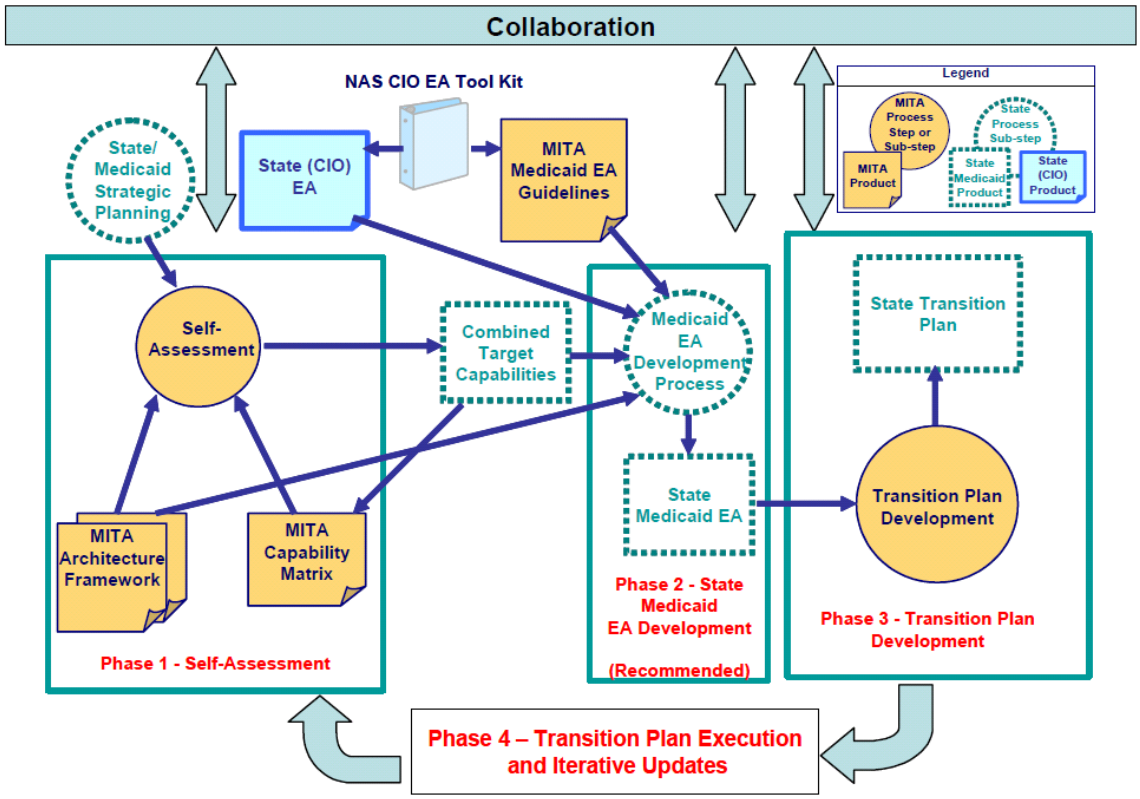

Figure 4 Transition Planning Phases
(From the CMS White Paper "Planning for MITA – An Introduction to Transition Planning")

The MITA Transition Planning Process is divided into four general phases:

- **Phase 1, State Self-Assessment (SS-A):** The State examines current capabilities (both business and technical) and compiles a list of new or combined target capabilities.
- **Phase 2, State Medicaid Enterprise Architecture (EA) Development:** The State collects the information necessary to project planning, utilizing its Medicaid or State EA. An EA provides a structure for aligning the State's business and technical architectures and ensures that IT investments are aligned with business needs.
- **Phase 3, Transition Plan Development:** The State identifies transition projects that will deliver the target capabilities identified in Phase 1. This phase should include the prioritization and staffing impacts of the projects based on the goals and objectives of IME.
- **Phase 4, Transition Plan Execution and Iterative Updates:** The State periodically reviews its progress through data compiled regarding the business outcomes of the transition. Any necessary business and technical changes are made in response to the **degree of progress**

toward target capabilities that is achieved. States may report their progress during legislative sessions or as part of other stakeholder activities.

Medicaid agency self-assessment results should be updated as the agency implements improvements to its business processes and supporting systems. EAs are constantly evolving; in a sense, they are never finished. Therefore, Medicaid agencies should focus on the parts of the EA most critical to their goals. The iterative approach allows incremental changes such that the entire transition plan does not need to be updated each time a change is made. Specific capabilities can be added, modified, and deleted, so that only the affected portions of the EA and the transition plan are updated as needed.

4.3.2 Recommendations for Ongoing Assessments

The contents of this report represent a description of the current business processes and supporting technical capabilities of Iowa's Medicaid Program. In MITA terms, this represents the As-Is. The current maturity levels for both the As-Is and the To-Be for the 80 identified business processes and the 34 technical support functions are documented in detail in Section 3.2.

As IME executes the projects identified in transition planning, the net effect is that the To-Be identified in Section 4.2 of this report becomes the ***new*** As-Is. It is at this point when IME should conduct a self-assessment of the business areas and technical functions affected by the specific project.

IME can utilize the process described in Section 2.2. This ongoing assessment process would ensure that the appropriate business process and technical capability documentation are current and that a ***new*** To-Be maturity level is established. This, in turn, will establish the foundation for planning the next project.

5.0 Appendices

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5.1 As-Is Business Process Interview Participants

ME01, ME02	
Normajean VanDenHuevel	DDM
Kelly Metz	IME
Jody Holmes	Core
Vasu Yeturu	Medical Services
Bethany Mengel	Medicaid Eligibility
Lisa Roberts	Data Warehouse
Linda Pierick	Medical Services
Jan Jordan	Medical Services
Jennifer Steenblock	Policy
Randy Clemenson	DHS
Sandy Paris	DDM
Dennis Janssen	IME
Deb Johnson	DHS

ME03, ME04	
Dennis Janssen	Policy
Jody Holmes	Core
Jennifer Steenblock	Policy
Linda Pierick	Medical Services
Jeremy Morgan	Member Services
Jan Jordan	Medical Services
Deb Johnson	Policy
Mary Tavegia	Provider Services
Julie Lovelady	Policy
Scott Hruska	Core
Kelly Metz	IME Policy
Lisa Roberts	Data Warehouse
Bob Schlueter	Provider Services
Desiree Smith	Provider Services
Courtney Lamb	Provider Services
Normajean VanDenHeuvel	DDM

ME05, ME07, ME08	
Jody Holmes	Core
Jennifer Steenblock	Policy
Jeremy Morgan	Member Services
Eileen Creager	Policy
Deb Johnson	Policy
Julie Lovelady	Policy
Randy Clemenson	DHS
Scott Hruska	CORE
Patti Ernst-Becker	Revenue Collection
John Davis	Revenue Collection
Vasu Yeturu	Medical Services
Lisa Roberts	Data Warehouse
Courtney Lamb	Provider Services
Jan Jordan	Medical Services
Linda Pierick	Medical Services
Kelly Metz	DHS Policy
Ruth Stoplin	Revenue Collections

ME06	
Mary Tavegia	Provider Services
Deb Johnson	Policy
Eileen Creager	Policy
Patti Ernst-Becker	DHS Policy
Brad Horn	AG's Office
Dennis Janssen	Policy
Jeremy Morgan	Member Services
Sally Nadolsky	Policy
Susan Parker	Policy
Cathy Coppes	Policy
Lin Christensen	Policy
Don Gookin	Policy
Cynthia Tracy	Policy
JoAnn Kazor	Policy
Timothy Weltzin	Policy
Sandy Pranger	POS
Scott Hruska	CORE
Julie Lovelady	Policy
Nancy Freudenberg	Appeals
John Davis	Revenue Collections
Courtney Lamb	Provider Services
Linda Pierick	Medical Services
Jean Schrum	Medical Services
Kelly Metz	DHS Policy

PM01,PM02	
Mary Tavegia	IME
Amy Perry	Provider Cost Audit
Robert Schlueter	Provider Services
Deb Johnson	Policy
Jody Holmes-via phone	Core
Jeremy Morgan	Member Services
Sandy Pranger	Pharmacy POS
Dennis Janssen	Policy
Desiree Smith	Provider Services
Kelly Metz	IME Policy
Harish Chhatlani	Core

PM03, PM06	
Mary Tavegia	Provider Services
Julie Lovelady	Policy
Jody Holmes	Core
Lisa Roberts	Data Warehouse
Amy Perry	Provider Cost Audit
Courtney Lamb	Provider Services
Desiree Smith	Provider Services
Joselyn Gibson	Core
Tim Weltzin	Policy
Robert Schlueter	Provider Services
Linda Pierick	Medical Services

PM04, PM07	
Mary Tavegia	IME
Patti Ernst-Becker	DHS Policy
John Davis	Revenue Collections
Jody Holmes	Core
Brian Fisher	SURS
Timothy Weltzin	Policy
Dennis Jenssen	Policy
Courtney Lamb	Provider Services
Desiree Smith	Provider Services
Amy Perry	Provider Cost Audit

PM04, PM07	
Bob Schlueter	Provider Services
Jan Jordan	Medical Services
Kelly Metz	IME Policy

PM05	
Mary Tavegia	Provider Services
Cathy Coppes	Policy
Jody Holmes	Core
Dennis Janssen	Policy
Patti Ernst-Becker	DHS Policy
Timothy Weltzin	Policy
John Davis	Revenue Collections
Brian Fisher	SURS
Nancy Freudenberg	DHS Appeals
Kelly Metz	IME Policy
Jan Jordan	Medical Services
Desiree Smith	Provider Services
Robert Schlueter	Provider Services

OM01, OM02, OM03	
Jennifer Steenblock	Policy
Jody Holmes	Core
Kelly Metz	IME Policy
Diane Morrill	Medical Services
Tonya Sickels	Medical Services
Cathy Fosselman	Core
Lisa Roberts	Data Warehouse
Jean Schrum	Medical Services

OM04, OM05	
Patti Ernst-Becker	DHS Policy
John Davis	Revenue Collections
Scott Hruska	Core
Amy Perry	PCA
Cathy Fosselman	Core
Robert Fleming	Revenue Collections
Tonya Sickels	Medical Services

OM06, OM07, OM08	
Scott Hruska	Core
Jody Holmes	Core
Alisa Horn	Core
Robert Schlueter	Provider Services
John Davis	Revenue Collections
Cynthia Tracy	Policy
Cathy Fosselman	Core
Robert Fleming	Revenue Collections

OM09, OM13	
Jody Holmes	Core
Robert Schlueter	Provider Services
Mary Tavegia	IME
Desiree Smith	Provider Services
Cathy Fosselman	Core

OM10, OM14	
Jody Holmes	Core
Scott Hruska	Core

OM10, OM14	
Desiree Smith	Provider Services
Mary Tavegia	IME
Sandy Pranger	Pharmacy POS
Joanne Rockey	CAO
Steve Russell	DDM
Cynthia Tracy	Policy

OM11, OM12	
Jody Holmes	Core
Scott Hruska	Core
Patti Ernst-Becker	DHS-Policy
Brian Fisher	SURS
John Davis	Revenue Collections

OM15, OM16	
Jody Holmes	Core
Cynthia Tracy	Policy
Jeanette Wiig	Fiscal Management
Kaye Kellis	FHWS/HIPP
Sara Schneider	HIPP
Cathy Fosselman	Core

OM17, OM21	
Jody Holmes	Core
Steve Russell	DDM
Joanne Rockey	CAO
Deb Johnson	Policy
Lucinda Wonderlich-Fuller	Eligibility
John Davis	Revenue Collections
Sandy Pranger	Pharmacy POS
Jill Whitten	Medicaid Eligibility
Kelly Metz	IME Policy
Randy Clemenson	DHS
Mary Tavegia	CAO
Sally Johnson	DDM
Normajean VanDenHeuvel	DDM

OM18/OM19	
Jody Holmes	Core
Scott Hruska	Core
Alisa Horn	Core
Mary Tavegia	CAO
Chad Bissell	Pharmacy
Cathy Fosselman	Core
Robert Schlueter	Provider Services
Beth Ginn	Revenue Collections
Michelle Greethurst	Revenue Collections
Jeremy Morgan	Member Services

OM20, OM22	
Jody Holmes	Core
Scott Hruska	Core
Lucinda Wonderlich-Fuller	Eligibility
Nicole Banken	
Mary Tavegia	IME
Sandy Pranger	Pharmacy POS

OM23, OM26	
John Davis	Revenue Collections
Jody Holmes	Core
Scott Hruska	Core
Cathy Fosselman	Core
Robert Fleming	Revenue Collections
Marcy Free	Revenue Collections
Min Tran	BA
Ben Chatman	Revenue Collections
Jill Whitten	Eligibility

OM24, OM25	
John Davis	Revenue Collections
Patti Ernst-Becker	DHS Policy
Robert Schlueter	Provider Services
Amy Perry	PCA
Brian Fisher	SURS
Mary Tavegia	CAO
Cathy Fosselman	Core

PI01, PI02	
Brian Fisher	SURS
Timothy Weltzin	IME
Sandra Pranger	Pharmacy POS
Desiree Smith	Provider Services
Bob Schlueter	Provider Services
Patti Ernst-Becker	DHS Policy
Vicki Shearer	Member Services

CM01, CM02, CM03, CM04	
Sally Nadolsky	Policy
Dennis Janssen	Policy
Linda Pierick	Medical Services

BR01, BR02, BR03, BR04	
Mary Tavegia	CAO
Joanne Rockey	CAO
Jody Holmes	Core
Jennifer Steenblock	Medical

CO01, CO08	
Mary Tavegia	CAO
JoAnn Cowger	CAO

CO02, CO03, CO04	
Mary Tavegia	CAO
JoAnn Cowger	CAO
Jody Holmes	Core
Patti Ernst-Becker	DHS Policy

CO06, CO07	
Mary Tavegia	CAO
Joanne Rockey	CAO
JoAnn Cowger	CAO
Jody Holmes	Core

CO05, CO09	
Mary Tavegia	CAO
Joanne Rockey	CAO
JoAnn Cowger	CAO
Jody Holmes	Core

PG01, PG02	
Eileen Creager	DHS Policy
Amy Perry	Provider Cost Audit
Patti Ernst-Becker	DHS Policy
Andi Dykstra	Medical/Pharmacy
Brad Horn	AG's Office
Jennifer Steenblock	Policy
Jody Holmes	Core
Scott Hruska	Core
Sandy Pranger	Pharmacy POS
Susan Parker	IME Policy
Kelly Metz	DHS Policy

PG03, PG07, PG10	
Amy Perry	PCA
Patti Ernst-Becker	DHS Policy
Alisa Horn	Policy
Jody Holmes	Core
Joe Havig	Fiscal Management
Sandy Pranger	Pharmacy POS
Susan Parker	DHS Policy
Mary Tavegia	DHS
Brad Neuweg	Fiscal Management
Jeff Marston	PCA
Kelly Metz	DHS Policy

PG04, PG05	
Eileen Creager	DHS Policy
Dennis Janssen	DHS Policy
Patti Ernst-Becker	DHS Policy
Alisa Horn	DHS Policy
Julie Lovelady	DHS Policy
Mary Tavegia	DHS
Kelly Metz	DHS Policy

PG06, PG09	
Alisa Horn	Policy
Daniel Hart	Legal
Joe Havig	Fiscal Management

PG06, PG09	
Julie Lovelady	Policy
Patti Ernst-Becker	DHS Policy
Amy Perry	PCA
Brad Neuweg	Fiscal Management

PG11, PG12, PG15	
Jody Holmes-via phone	Core
Mary Tavegia	IME
Brad Horn	AG's Office
Amy Perry	PCA
Sandy Pranger	Pharmacy POS
John Davis	Revenue Collections
Brian Fisher	SURS
Jeanette Wiig	Fiscal Management
Rosemary Johnson	Fiscal Management
Natalie Storm	Fiscal Management
Nancy Foote	Fiscal Management
Lucinda Wonderlich-Fuller	Eligibility
Jill Whitten	Eligibility
Ben Chatman	Revenue Collections
Deb Johnson	Policy
Jennifer Steenblock	Policy
Joanne Rockey	CAO
JoAnn Cowger	CAO
Desiree Smith	Provider Services
Courtney Lamb	Provider Services
Joselyn Gibson	Core
Harish Chhatlani	Core
Kelly Metz	IME Policy

PG08, PG18, PG19	
Brad Neuweg	DHS Fiscal
Mary Tavegia	CAO
Joe Havig	DHS-Fiscal
Jody Holmes	CORE
Scott Hruska	Core
Amy Perry	PCA
Patti Ernst-Becker	DHS Policy
Alisa Horn	Policy
JoAnn Cowger	CAO
Rosemary Johnson	DHS-Fiscal
Julie Lovelady	Policy
Harish Chhatlani	Core

PG13, PG14	
Amy Perry	PCA
Patti Ernst- Becker	DHS Policy
Alisa Horn	Policy
Deb Johnson	Policy
Jody Holmes	Core
Jennifer Steenblock	Policy
Jan Jordan	Medical Services
Kelly Metz	DHS Policy
Harish Chhatlani	Core
Chad Bissell	Pharmacy

PG16, PG17	
Jody Holmes	Core
Mary Tavegia	IME
Deb Johnson	Policy
Jennifer Steenblock	Policy
Dennis Janssen	Policy
Brad Horn	AG's Office
Julie Lovelady	IME Policy
Kelly Metz	IME Policy

5.2 Technical Questionnaire and Responses

See the accompanying document, IME_MITA_Technical_Questinnaire_V0_1.doc, containing a blank questionnaire.

See the accompanying document, IME_SS-A_TechAssesQuest_Response_Composite.doc, for the raw data collected via the FOX Technical Questionnaire. This is the data that was used to perform the Technical Assessment.

5.3 FOX Defined TBD Capabilities

The following table contains the capabilities that FOX developed to use in the situations where the Business Capability Matrix contained "To be developed" in the MITA Framework 2.0.

Capabilities for Use where the BCM is noted as TBD
Level 1
The processes is primarily manual
Process is soloed – more than one portion of the agency performing the same function
There are no data standards in use relative to this process
Relative to this process, the agency focuses on meeting compliance thresholds dictated by state and federal regulations
Level 2
Processes are a mix of manual and automated
Centralization beginning and/or central coordination beginning to taking place
Standards internal to the agency and HIPAA transaction standards have been or are beginning to be introduced
Relative to this process, the agency focuses on cost management and improving quality
Level 3
Processes are primarily automated except where the State deems automation to be inappropriate.
Fully centralized or centrally coordinated
MITA data and interface standards have been implemented
Relative to this process, the agency focuses on coordination with other agencies and collaboration in adopting national (MITA) standards and developing shared business services
Level 4
There is widespread and secure access to clinical data
The agency's focus is on program improvement
Level 5
National (and international) interoperability allows the Medicaid enterprise to focus on fine tuning and optimizing program management, planning, and evaluation.