Part I — Business Architecture

Appendix D — Business Capability Matrix Details

Introduction

Appendix D contains the Business Capability Matrix (BCM) forms. "Matrix" refers both to the composite of all business capabilities which could be displayed as a very large table, and to the individual set of capabilities that map to a business process. Each business process has a corresponding business capability matrix representing 1-5 levels of maturity. When a State performs a self-assessment against the MITA Framework, it starts by determining the current level of maturity of each business process and the improved level it seeks to achieve in the future. The BCM is the primary tool for selecting the appropriate level.

The MITA Framework is a work in progress. The contents of the BCM are under development. Collaboration among States, CMS, and vendors is needed to refine, improve, and complete the BCM.

The five levels of maturity in the BCM are based on the definitions of levels in the MITA Maturity Model. The business capabilities (along with the Logical Data Model) are the basic building blocks of the framework. Business capabilities describe information requirements that are defined in the Logical Data Model. (It is possible to begin by defining the data model which in turn drives the definition of the business capability. The MITA Framework defines the business processes and business capabilities first because of the availability of State business process models.)

The business capability is also supported by technical enablers described in Part III Chapter 5, Technical Capability Matrix (TCM). Technical enablers are assigned to the same 1-5 levels of maturity.

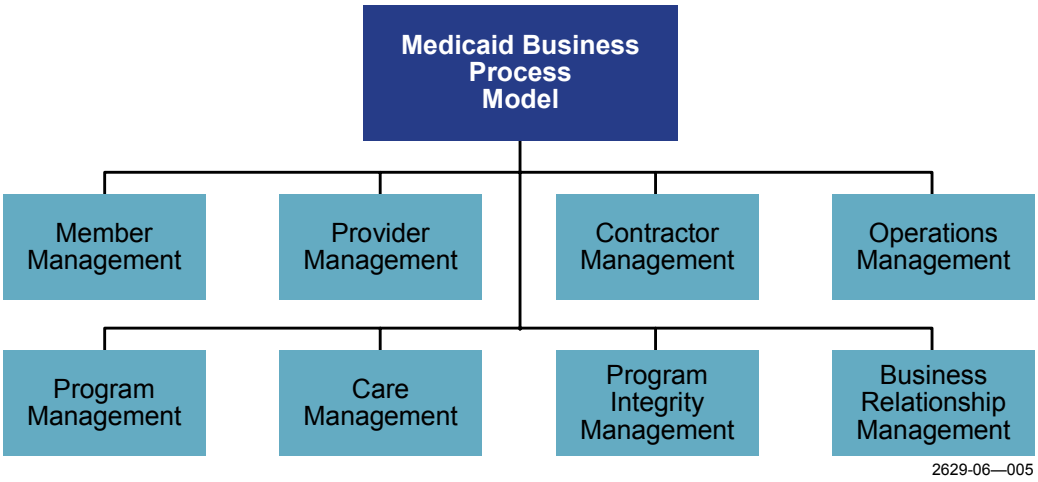
Business services (see Part III Chapter 4) define the physical implementation of a business capability. So, the main link between the Business Architecture and the Technical Architecture is the business capability to business service association. Both the business service and the business capability map to the Logical Data Model. See the Introduction to the MITA Framework 2.0 at the front of this volume for more discussion of these interrelationships.

How to Read the BCM Form

Business Area and Title of Business Process

[Business Process Title] Edit Claim/Encounter				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions [for each Level of Maturity]				
Describe Level 1 capabilities.	Describe Level 2 capabilities.		Some business processes may not have a Level 4 or 5 business capability.	
Business Capability Qualities: Timeliness of Process (TBD)				
Define Timeliness at Level 1 in measurable terms.	Define Timeliness at Level 2.		**NOTE:** Qualities are not defined for all capabilities	
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: To Be Developed				
		Specify conformance criteria used to determine if the Level 3 capability has been implemented as intended.	Conformance criteria apply to Level 3 and above.	

The BCM follows the same organization as the Business Process Model in Appendix C. The high level view of the BPM/BCM is shown in the figure below.



The table below shows the relationship between the business process and the business capability matrix. Some differences between the BPM and the BCM are:

- Generally, the BPM is more mature and more fully developed.
- Business capabilities fall into three groups in terms of completeness:
  - Descriptions and Qualities have been completed but not reviewed
  - Descriptions are completed but Qualities have not been added
  - There is a placeholder for the business capability
- In some cases, one BCM is associated with two business processes, e.g., Edit Claim/Encounter and Audit Claim/Encounter.
- Red font indicates that the component is missing. To-be-developed text is shown as TBD.

Business Area	Business Process	Business Capability
Member Management (ME)	ME Determine Eligibility	ME Determine Eligibility Business Capabilities
	ME Disenroll Member	ME Disenroll Member
	ME Enroll Member	ME Enroll Member Business Capabilities
	ME Inquire Member Eligibility	ME Inquire Member Eligibility Business Capabilities
	ME Manage Applicant and Member Communication	ME Manage Applicant and Member Communication Business Capabilities
	ME Manage Member Grievance and Appeal	ME Manage Member Grievance and Appeal
	ME Manage Member Information	ME Manage Member Information Business Capabilities
	ME Perform Population and Member Outreach	ME Perform Population and Member Outreach Business Capabilities
Provider Management (PM)	PM Disenroll Provider	PM Disenroll Provider
	PM Enroll Provider	PM Enroll Provider Business Capabilities
	PM Inquire Provider Information	PM Inquire Provider Information Business Capabilities
	PM Manage Provider Communication	PM Manage Provider Communication Business Capabilities
	PM Manage Provider Grievance and Appeal	PM Manage Provider Grievance and Appeal Business Capabilities
	PM Manage Provider Information	PM Manage Program Information Business Capabilities
	PM Perform Provider Outreach	PM Perform Provider Outreach Business Capabilities
Contractor Management (CO)	CO1 Award Health Services Contract	CO1 Award Health Services Contract Business Capabilities
	CO1 Close out Health Services Contract	CO1 Close out Health Services Contract Business Capabilities
	CO1 Manage Health Services Contracting	CO1 Manage Health Services Contracting Business Capabilities

Business Area	Business Process	Business Capability
	CO2 Award Administrative Contract	CO2 Award Administrative Contract Business Capabilities
	CO2 Close-out Administrative Contract	CO2 Close-out Administrative Contract Business Capabilities
	CO2 Manage Administrative Contract	CO2 Manage Administrative Contract Business Capabilities
	CO3 Manage Contractor Information	CO3 Manage Contractor Information Business Capabilities
	CO4 Manage Contractor Communication	CO4 Manage Contractor Communication Business Capabilities
	CO4 Perform Potential Contractor Outreach	CO4 Perform Potential Contractor Outreach Business Capabilities
	CO4 Support Contractor Grievance and Appeal	CO4 Support Contractor Grievance and Appeal Business Capabilities
	CO3 Inquire Contractor Information	CO3 Inquire Contractor Information
Operations Management (OM)	OM1 Authorize Referral	OM1 Authorize Referral Business Capabilities
	OM1 Authorize Service	OM1 Authorize Service Business Capabilities
	OM1 Authorize Treatment Plan	OM1 Authorize Treatment Plan Business Capabilities
	OM2 Apply Claim Attachment	OM2 Apply Claim Attachment Business Capabilities
	OM2 Apply Mass Adjustment	OM2 Apply Mass Adjustment Business Capabilities
	OM2 Audit Claim-Encounter	OM2 Edit and Audit Claim-Encounter Business Capabilities
	OM2 Edit Claims-Encounter	One business capability matrix for two Edit and Audit business processes
	OM2 Price Claim – Value Encounter	OM2 Price Claim – Value Encounter Business Capabilities
	OM3 Prepare COB	OM3 Prepare Coordination of Benefits Business Capabilities

Business Area	Business Process	Business Capability
	OM3 Prepare EOB	OM3 Prepare Explanation of Medical Benefits Business Capabilities
	OM3 Prepare Home and Community Based Services Payment	OM3 Prepare Home and Community Based Services Payment Business Capabilities
	OM3 Prepare Premium EFT-check	OM3 Prepare Provider and Premium-Capitation EFT-Check Business Capabilities
	OM3 Prepare Provider EFT-check	One business capability matrix for two EFT/Check business processes
	OM3 Prepare Remittance Advice-Encounter Report	OM3 Prepare Remittance Advice-Encounter Report Business Capabilities
	OM4 Prepare Capitation Premium Payment	OM4 Prepare Capitation Payment Business Capabilities
	OM4 Prepare Health Insurance Premium Payment	OM4 Prepare Health Insurance Premium Business Capabilities
	OM4 Prepare Medicare Premium Payments [singular]	OM4 Prepare Medicare Premium Payment Business Capabilities
	OM5 Inquire Payment Status	OM5 Inquire Payment Status Business Capabilities
	OM5 Manage Payment Information	OM5 Manage Payment Information Business Capabilities
	OM6 Calculate Spend-Down Amount	OM6 Calculate Spend-down Amount Business Capabilities
	OM6 Prepare Member Premium Invoice	OM6 Prepare Member Premium Invoice Business Capabilities
	OM7 Manage Drug Rebate	OM7 Manage Drug Rebate Business Capabilities
	OM7 Manage Estate Recovery	OM7 Manage Estate Recovery Business Capabilities
	OM7 Manage Recoupment	OM7 Manage Recoupment Business Capabilities
	OM7 Manage Settlement	OM7 Manage Settlement Business Capabilities
	OM7 Manage TPL Recovery	OM7 Manage TPL Recoveries Business Capabilities

Business Area	Business Process	Business Capability
Program Management (PG)	PG1 Designate Approved Service Drug Formulary	PG1 Designate Approved Service Drug Formulary Business Capabilities
	PG1 Develop and Maintain Benefit Package	PG1 Develop and Maintain Benefit Package Business Capabilities
	PG1 Manage Rate Setting	TBD
	PG2 Develop Agency Goals and Objectives	TBD
	PG2 Develop and Maintain Program Policy	TBD
	PG2 Maintain State Plan	TBD
	PG3 Formulate Budget	TBD
	PG3 Manage FFP for MMIS	PG3 Manage FFP for MMIS Business Capabilities
	PG3 Manage F-MAP	TBD
	PG3 Manage State Funds	PG3 Manage State Funds Business Capabilities
	PG4 Manage 1099s	PG4 Manage 1099s Business Capabilities
	PG6 Generate Financial and Program Analysis Report	PG6 Generate Financial and Program Analysis Report Business Capabilities
	PG6 Maintain Benefits-Reference Information	PG6 Maintain Benefits Reference Information Business Capabilities
	PG6 Manage Program Information	TBD
Business Relationship Management (BR)	BR Establish Business Relationship	Plan to do one consolidated Business Capability for all 4
	BR Manage Business Relationship Communications	
	BR Manage Business Relationship	
	BR Terminate Business Relationship	

Business Area	Business Process	Business Capability
Program Integrity Management (PI)	PI Identify Candidate Case	PI Identify Candidate Case Business Capabilities
	PI Manage Case	TBD
Care Management (CM)	CM Establish Case	CM Establish Case
	CM Manage Case	TBD
	CM Manage Medicaid Population Health	TBD
	CM Manage Registry	TBD

Member Management

ME Determine Eligibility: Business Capabilities[1]

Determine Eligibility				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the Determine Eligibility business process is designed to serve social services programs and FFS Medicaid programs. The process is constrained by FAMIS or state eligibility system functionality. Indeterminate format for application data. Information is manually validated. Staff contact external and internal document verification sources via phone, fax. Decisions may be inconsistent. Requires large staff. Decisions take several days. There are many pathways for determining eligibility. At Level 1, eligibility determination may occur in silos without sharing or coordination, i.e., different processes for each type of eligibility. When eligibility information is transferred from FAMIS to MMIS, it must be converted and data is lost. In addition, transfers must be scheduled for batch transmission outside of production cycles,	At this level, the Determine Eligibility business process is by extended by "work-arounds" to meet the needs of programs besides FFS. Benefit package selections may still be limited for traditional Medicaid programs. However, Waiver programs may be structured to permit more flexibility around selection of services and providers within a benefit package. Application data may be standardized within the state. Some applications still on paper. Verifications are a mix of manual and automated. Consistency is improved. Requires fewer staff. Process takes less time than Level 1. There are many pathways for determining eligibility for low income applicants. At Level 2, eligibility determination may still occur in silos without sharing or coordination. Some efforts are made toward standardizing eligibility determination data so that it	At this level, the Determine Eligibility business process benefits from member-centric, No Wrong Door initiatives and the technology support provided by SOA and rules-engines. All programs introduce flexibility within benefit packages, enabling "consumer driven" health care with more choices among services and provider types available within the funding limits of all benefit packages for which the member is eligible. Design of benefit packages is manual and is based on limited paper-based access to external clinical data. Application data are standardized. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate. At Level 3, different types of eligibility pathways are merged into a single process. This is a	At this level, the Determine Eligibility business process ease of access to external sources of data, including clinical data, augment Level 3 capabilities. External and internal validation sources automatically send notice of change in member status, e.g., change in income, other coverage, residency, immigrant status, spend-down accumulation. Re-determination notices are automatically generated. Direct access to clinical data improves the determination process through immediate validation in the medical record. Manual steps only required for exception handling. Services and providers are selected within funding limits of benefit packages available to the member based on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally	At this level, the Determine Eligibility business process capabilities are augmented by national interoperability, permitting the eligibility process to send inquiries to any other agency, state, federal, or other entities in any part of the country. Agency receives automated notifications from the SSA and other in-state and other state and federal agencies with which it has data sharing agreements. Consumer-driven benefit packages are designed and updated real time based on collaborative interfaces with members' federated electronic health records. As clinical data indicates altering priority of services, the benefit package is optimally reconfigured for best health outcome within funding limits.

ME Determine Eligibility: Business Capabilities[1]

Determine Eligibility				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
which impedes timely availability. Benefit packages selections have pre-set services and provider types. Each eligible may be offered only packages available via eligibility determination pathway taken. Within each silo, eligible may only be assigned to the best available package available despite eligibility for more expansive services because systems may be limited to supporting one eligibility span at a time. Spend-down amounts are calculated manually. Member's record reflects whether spend-down amount is reached. Until spend-down is met, the Edit process in the Provider Payment Adjudication business area will flag the member's claims to be denied based on eligibility. When spend-down is met, the Edit process will validate that the claim passes eligibility edits. See Calculate Spend-down process in the Operations Management, Member Payment business	is more easily shared and compared. Spend-down continues to be calculated manually.	"one-stop-shop" perspective for the applicant. One door to all applicable eligibility applications. Applicants may initiate an application from home or a community location. A consolidated "Determine eligibility process" manages all categories. Spend-down is calculated automatically by the Calculate Spend-down process in the Operations Management, Member Payment business area. Spend-down is treated as a deductible that these eligibles must pay out-of-pocket before Medicaid will pay. The spend-down amount in the member's record is decremented by this process. Until spend-down is met, the Edit process in Provider Payment Adjudication will deny the claim. Once spend-down is met, the Edit process will validate that the claim passes eligibility edits.	appropriate, and functional competencies. Design of benefit packages is automated with electronic access to electronic clinical data.	

ME Determine Eligibility: Business Capabilities[1]

Determine Eligibility				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
area.				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

[1] The Member Management Business Area services members through outreach, enrollment, information management, communications, and support services. The Business Objectives for this Business Area are: Improve quality of members' health services; match needs of the population with availability of appropriate services; satisfy members and other stakeholders; prevent illness; improve outcomes.

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ME Enroll Member: Business Capabilities[1]

Enroll Member				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Enrollment processes are paper-based and siloed within programs with no cross program coordination. Staff makes decisions autonomously and without consultation with other programs. Eligibility determination must precede enrollment and is done separately. Enrollment policies, procedures, benefits and application forms are program specific. Applicants must submit paper application forms to each program separately and responses may take several days. Process focus is on manually applying the agency's business rules to ensure that enrollment meets state and federal requirements. Staff manually verifies financial, socio-economic and health status information. Enrollment in managed care and waiver programs requires cumbersome extension of traditional fee-	Enrollment processes begin to be coordinated across siloed programs and centralized by the enterprise, but there are still many "doors" and enrollment pathways. Staff collaborates with other agencies to receive, triage, and process paper and some electronic applications per "No Wrong Door" policies so that applicants can apply once for all programs. Eligibility determination still proceeds enrollment but may be done in same process. Applicants may submit applications online, but results are not real time. Automated program-specific business rules ensure that enrollment is in compliance with state and federal law and policy; and fully supports enrollment in managed care and waiver programs. Some verification of financial, socio-economic and health status information is automated, but not real time. Some ability to blend benefits	Enrollment pathways are merged into a single process. This is a "No Wrong Door" perspective for the member - one door to all applicable eligibility/enrollment processes. All member enrollment records are stored and accessible with service calls in the Medicaid member registry. Both eligibility determination and enrollment in specific programs are handled simultaneously without redundant data. Applicants may initiate an eligibility/enrollment application online from home or a community location without staff assistance and receive some responses real time. Staff collaborates with other agencies to receive standardized, electronic member enrollment applications per "No Wrong Door" policies so that applicants can apply once for all programs.	Enrollment and eligibility determination processes are integrated with applications at the point of service – e.g., in schools when eligible for subsidized lunch and health programs; when applying for unemployment; when receiving public health services that result in certain diagnoses; or during a health care encounter with electronic health record systems, e.g., providers are alerted by their EHRs decision support systems that the patient's data meets criteria for Medicaid program eligibility and prompts the provider to advise the patient. If the provider's system is service enabled, it can prepopulate appropriate enrollment application(s) and to request additional information needed from the provider/applicant. The applicant is also able to use online PHR or Web portal to fill out a pre-populated application. Automated verification and	Enrollment/eligibility determination processes are automated services triggered by point of service applications including PHRs and EHRs and run collaboratively. The enrollment/eligibility process (1) verifies information provided by the point of service application by calling federated registries, health record repositories and other data sources; (2) determines eligibility; (3) designs a member specific benefit package; (4) enrolls the member and provides the results via the point of service application. The applicant is also able to use online PHR or Web portal to fill out a pre-populated application. Benefits are member-specific, seamless and coordinated package of quality, efficacious benefits that meet each member's health, functional, cultural and linguistic needs. Agency receives automated

ME Enroll Member: Business Capabilities[1]

Enroll Member				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
for-service processes. Benefits cannot be "blended" across programs. Staff does not have the time or means to focus on meeting members' health, functional, cultural or linguistic needs. Staff must send paper enrollment notification to contractors.	across programs. Automation enables staff to focus on meeting members' health, functional, cultural, and linguistic needs.	Automated cross program business rules ensure that enrollment in multiple programs are in compliance with state and federal law and policy. All verification of financial, socio-economic and health status information is automated and some is real time. Automated business rules facilitate design of seamless and coordinated package of quality, efficacious benefits that meet each member's health, functional, cultural and linguistic needs. Contractors and providers can query the registry to determine eligibility and program enrollment. Contractors may batch download enrolled members rather than receive the HIPAA 834.	application response are real time. Benefits are member-specific, seamless and coordinated package of quality, efficacious benefits that meet each member's health, functional, cultural and linguistic needs. Agency can automatically query regional patient registries for member enrollment information for verification and adjudication purposes such as COB.	enrollment notifications from the SSA, EHRs, PHRs, intra- and interstate sources and federal agencies with which it has data sharing agreements for verification and adjudication purposes such as COB. More effective because information about all enrollment events of interest are pushed vs. querying potential sources of enrollment data.
Business Capability Qualities: Timeliness of Process (TBD)				
Decisions on application may take several days; longer if verification of information is difficult. Contractors do not receive timely enrollment information.	Process takes less time than Level 1. Although data is electronic, much of the review and verification of information for waiver programs must be done manually.	Turnaround time on application decision can be immediate. Medicaid and contractor member registries are updated in near real time as changes occur.	Turnaround time is immediate.	Turnaround time is immediate, on a national scale.

ME Enroll Member: Business Capabilities[1]

Enroll Member				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	Managed care enrollment is rule driven and automated; applicants and members communicate via Web portal for increased timeliness.			
Data Access and Accuracy				
Enrollment data and format are indeterminate. Enrollment applications are not standardized and may still be hard copy. Some enrollment records are stored electronically but storage is not centralized. Member data, including ID, demographics and health status, is not comparable across programs reducing ability to monitor program outcomes or detect fraud and abuse. Notifications to contractors are state-specific and differ by contractor type.	Enrollment data are standardized within the agency. Enrollment applications are standardized and electronic; they are received from many sources and triaged to appropriate programs for processing. Enrollment records for different programs continue to be stored separately but can be accessed and aggregated as needed. HIPAA contractors receive standardized 834 Enrollment Transaction, but non-HIPAA contractors receive state-specific enrollment transactions. Although data comparability is improved and supports use of performance measures to evaluate providers, performance data is only periodically measured and requires sampling and statistical calculation.	Enrollment application and exchange data are standardized nationally among Medicaids improving access and accuracy. All programs use the HIPAA 834 Enrollment transaction and implement a standard response transaction from the contractors for corrections. Enrollment records are stored in either a single member registry or federated Agency member registries that can be accessed by all applications. Member ids are linked algorithmically based on other standardized data so that enrollment records are automatically linked across programs. Providers, members, and state enrollment staff have secure access to appropriate and accurate data on demand.	Medicaid member registries are federated with regional data exchange networks. Agency may auto/ad hoc query registries for standardized, timely, and complete enrollment data about members for verification and adjudication purposes. Authorized, authenticated parties have virtual, instant access to member data locally.	Member registries are federated with regional data exchange networks across the country and if desired, internationally. Agency automatically receives standardized, timely, and complete enrollment data notifications about members for verification and adjudication purposes. Authorized, authenticated parties have virtual, instant access to enrollment data, nationally.

ME Enroll Member: Business Capabilities[1]

Enroll Member				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Effort to Perform; Efficiency				
Enrollment may occur in silos without coordination, i.e., different processes and multiple pathways for each type of enrollment. Applicants and members can submit applications, make inquiries, and choose providers and MCOs on paper. Staff contact external and internal financial, socio-economic, demographic and health status verification sources via phone, fax.	Enrollment processes continue to be handled by siloed programs according to program-specific rules. Applicants and members can submit enrollment applications, make inquiries, and choose providers and MCOs electronically via a portal which lessens effort. Verifications and enrollment are a mix of manual and automated steps.	Applications are only submitted electronically. Medicaid centralizes all member enrollment processes; has a single set of enrollment rules. Enrollments and verifications are full automated. Verifications are still between trading partners and centralized repositories vs. queries to federated information sources. Manual steps may continue only for exceptions. Services created for the enrollment process, including the Web application, the enrollment and verification interfaces, registry calls and synchronization mechanisms can be shared among states.	Any data exchange partner within a federated region can query and receive appropriate data relating to an enrolled member. Internal and regional person/patient registries and other enrollment data sources can be auto/ad hoc queried for changes in verification or enrollment status; supports detection of fraudulent or erroneous in real time.	Any data exchange partner nationally, and even internationally can query and receive appropriate data relating to an enrolled member. Nationally interoperable person/patient registries and other enrollment data sources (SSA) automatically send notice of changes in verification or enrollment status, eliminating the need to re-verify; supports detection of fraudulent or erroneous enrollment in real time anywhere in the U.S.
Cost-Effectiveness				
Requires a large staff to meet targets for manual enrollment of members. Siloed enrollment processes result in redundant infrastructure, effort and costs.	Process requires fewer staff than Level 1 and produces better results. Fewer applicants and members are enrolled erroneously, reducing program costs.	Process requires fewer staff than Level 2 and improves on results. Shared services and inter-agency collaboration contribute to streamline the process.	Full automation of the process plus ability to auto/ad hoc query local person/patient registries reduces staff needed for verification, COB and fraud detection and improves cost savings. Enrollment alerts to providers	More effective enrollment data exchange because information about all enrollment events of interest are pushed vs. querying potential sources of enrollment data.

ME Enroll Member: Business Capabilities[1]

Enroll Member				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
			reduces staff needed for enrollment outreach and verification of health status.	
Accuracy of Process Results				
Much of the application information is manually validated and verification may be difficult resulting in increase error rates and potential for fraud. Decisions may be inconsistent. Due to limited monitoring and re-verification of enrolled members' status, ineligible members may continue to be enrolled. MMIS and Contractor member registries are frequently not synchronized.	Automation of business rules improves accuracy of validation and verification. Automated application of enrollment business rules improves consistency. Permits blending of program benefits to provide more appropriate services to members. Standardization of enrollment data, verification automation, business rules and workflow capabilities, and coordination across programs enable monitoring and re-verification of enrolled members' status, reducing enrollment of ineligible members. Use of standardized, electronic enrollment transactions somewhat improves accuracy of enrollment data exchange between MMIS and Contractor member registries, but these may not be synchronized because of periodic batch updates.	Automation of enrollment and verification data interchange improves timeliness and quality of data. Synchronization of eligibility and enrollment processes ensures data and decision consistency, thereby improving results. Automated enrollment coordination of program benefits improves the members' access to appropriate services and compliance with state/federal law.	Ability to auto/ad hoc query federated registries to access enrollment and verification data increases data reliability and completeness, ensuring better process results.	Automated notification of enrollment events of interest further increases data reliability and completeness, ensuring better process results.

ME Enroll Member: Business Capabilities[1]

Enroll Member				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Utility or Value to Stakeholders				
Focus is on accurately processing enrollment and manually verifying information as efficiently as possible. Staff does not have time to focus on health, functional, cultural and linguistic compatibility of provider or program for the member, or member satisfaction.	Automation and coordination of enrollment processes enable staff to focus more on enrolling members into the most appropriate program(s), and optimizing health, functional, cultural and linguistic appropriateness of benefits and providers for member satisfaction.	Members experience a seamless and efficient eligibility/enrollment process no matter how or where they contact the Agency. E.g., no redundant request for member data; no need to schedule appointments, greater ability to verify data online. Members receive benefit packages (merged from all programs for which the member is eligible) specifically designed to meet individual's health, functional, cultural and linguistic needs	Applicants and providers are "pushed" information about and applications for potential eligibility/enrollment opportunities, automating member outreach.	Applicants are "presumptively eligiblized/enrolled" automatically at the point of care based on national verification of health and socio-economic data, ensuring immediate access to needed health care.
Conformance Criteria for Each Level: (TBD)				

[1] The Enroll Member Business Area services members through outreach, enrollment, information management, communications, and support services. The Business Objectives for this Business Area are: Improve quality of members' health services; match needs of the population with availability of appropriate services; satisfy members and other stakeholders; prevent illness; improve outcomes.

ME Disenroll Member: Business Capabilities [To Be Developed]

Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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ME Manage Member Information: Business Capabilities

Manage Member Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the Manage Member Information business process is designed to serve FFS Medicaid programs and meet MMIS certification requirements such as MARS and MSIS reporting. Data requests are received from disparate sources in indeterminate formats. Data is shared in batch on a scheduled or ad hoc basis. Validation is inconsistent and not rules-based. There are delays in completing updates and loading member data generated from multiple sources. Duplicate entries may go undetected. Irregular update notification to interested users and processes. Legacy member files, lack of integration with the FAMIS and mailing paper ids may limit Agencies to monthly eligibility periods vs. day based eligibility/enrollment.	At this level, the Manage Member Information business process is by extended by "work-arounds" to meet the needs of programs besides FFS. Data requests are standardized; requested and scheduled data extraction is increasingly automated. Rule-based validation and data reconciliation is more consistent and maintains integrity of data repository. Updates are automated with date stamp and audit trail; and notification to interested users and processes is immediate. Integration with FAMIS supports day based eligibility/enrollment.	At this level, the Manage Member Information business process benefits from member-centric, No Wrong Door initiatives and the technology support provided by SOA and rules-engines. Member information is integrated via a Member Registry, which may either contain integrated records of member eligibility data or provide federated access to other Member Registries as appropriate. Standard interfaces (trigger event and results; messages to external entities), standardized data, consistent business rules and decisions, easy to change business logic. Manage Member Information is handled by a business service.	At this level, the Manage Member business process improves data availability and access for external users regionally. Member Registry is federated with RHIO so that other stakeholder applications, including PHRs can access member information to the extent authorized. Clinical data is associated with the member. Ability to access clinical data electronically to calculate performance and outcome measures improves quality of care, care/disease management protocols, and program design.	At this level, the Manage Member business process improves data availability and access for external users nationally. Member Registry accessed collaboratively by authorized data sharing partner applications nationally during shared business processes such as verifying COB. Capability is available nationally. Member information (de-identified where necessary) can be shared across states.
Business Capability Qualities: Timeliness of Process (TBD)				
Manual and semi-automated	Timelier member updates	Updates and data extractions	Turnaround time is	Turnaround time is

ME Manage Member Information: Business Capabilities

Manage Member Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
steps delay updates, maintenance processes and require system down-time. Inadequate audit trails.	and data extractions.	can be immediate. Data exchange partners receive update notifications instantly.	immediate. Updates are available to all authorized data exchange partners.	immediate, on a national scale.
Data Access and Accuracy				
Updates are made to individual files manually. Data issues: duplicate identifiers, discrepancies between data stores, and information quality and completeness.	Automated updates are made to individual files and databases. Databases may be relational.	Updates, notifications, and data extractions (e.g., MSIS eligibility reports and MCO enrollment rosters) are standardized. Member records are stored in either a single Member Registry or federated Member Registries that can be accessed by all authorized applications.	Medicaid Member Registries are federated with regional data exchange networks. Updates, notifications and data extractions are accessible to all authorized data exchange partners.	Medicaid Member Registries are federated with regional data exchange networks across the country and if desired, internationally. Updates notifications are automatically sent to all authorized interested data exchange partners.
Effort to Perform; Efficiency				
Staff must key new information; make updates manually; reconcile and validate data manually. Legacy systems limit Agency's ability to start and end eligibility in MCOs within a month, thereby increasing cost of capitation premiums paid for members who become ineligible during the month.	Updates are automatically processed. Edits are consistent. Fewer staff required to support. MCO premiums are paid on a daily rate, lowering capitation premium costs for ineligible members.	Updates are distributed to data sharing partners. One stop shop for entities who share members. Further reduction in staff support.	Clinical data could be used to trigger member registry updates and to push member data to other applications, e.g., EHRs, Immunization registries; and care/disease management applications. Ability to access clinical data electronically to calculate performance and outcome measures improves quality of care, care/disease management protocols, and program design.	Any data exchange partner can send a notification regarding a member record update to any other program in the USA. Nationally interoperable validation sources automatically send notice of change in member enrollment and socio-economic status, eliminating the need to re-verify; supports fraud detection in real time anywhere in the USA.

ME Manage Member Information: Business Capabilities

Manage Member Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Cost-Effectiveness				
Requires numerous data entry staff to key new and updated information, and reconcile duplicates and data inconsistencies. IT staff needed to load member information generated from other systems.	Automation leads to fewer staff than Level 1.	Distributed update notifications to federated member registries reduces staff requirements.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who focus on performance and outcome measures; care/disease management; improves COB and fraud detection; and benefit package design to reduce program costs. Regional, federated member registries eliminate redundant overhead. Using clinical data electronically vs. paper charts lowers costs to calculate performance and outcome measures.	Gains of Level 4 are further improved by access to Member updates on a national basis. Optimizes performance and outcome measures; care/disease management; improves COB and fraud detection; and benefit package design, greatly reducing program costs.
Accuracy of Process Results				
Updates and reconciliations must be manually validated. Process focus is on compliance with agency requirements and less on ensuring timely availability of quality/complete data for users.	Automation improves accuracy of validation, verification, and reconciliation of database updates.	Member data is associated algorithmically to support federated access, automated updates, reconciliation and extraction of complete and quality data.	Automation and association of clinical data to member records improves accuracy of enrollment, performance measurement and care management processes.	National access to member enrollment/clinical data improves research, reporting, performance measures, outcome studies; care/disease management; and fraud detection.
Utility or Value to Stakeholders				
Member information is maintained and available, primarily on a scheduled or	Automated maintenance of member information ensures that timely, accurate data are	Member and staff satisfaction improves because data accessibility increases the	Providers, members, and care managers access standardized Member	Same as Level 4, on a national scale, where authorized. Additionally, the

ME Manage Member Information: Business Capabilities

Manage Member Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
request basis to other business processes and users.	available to support all processes needing member information, e.g., MCO enrollment rosters, COB, adjudication, etc.	efficiency, speed, and accuracy of eligibility/enrollment and other processes.	Registries to view clinical data needed for EHRs, PHRs, and care/disease management. Ability to access de-identified member clinical data electronically to calculate performance and outcome measures improves member and regional patient care.	ability to access de-identified member clinical data improves research and calculations of performance and outcome measures, improving patient care nationally.
Conformance Criteria for Each Level: (TBD)				

ME Inquire Member Eligibility: Business Capabilities

Inquire Member Eligibility Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Inquiries about members' eligibility/enrollment in a program, coverage of benefits, etc. are received in non-standard formats. Providers cannot be sure of the appropriate source from which to request eligibility verification. Most requests are sent via telephone, fax, or point of service device. Media, data format and content differ by program. Providers often depend on paper member ID cards that can be inaccurate. Newly eligible members must wait to receive mailed ID cards or the provider must verify eligibility by telephone. Verification is performed manually. Responses are inconsistent, sometimes incorrect, and untimely.	Eligibility Verification Requests and Responses are communicated using HIPAA X12 270/271 and NCPDP Telecommunications Guide v 5.1 and Batch Guide v 1.0. The sources of eligibility information are siloed within different programs; member data is not integrated and not semantically interoperable across programs. Routine inquiries for member information are automated within the agency via AVRS, point of service devices, Web portal, EDI. Responses are immediate or within batch. Responses are consistent, correct, and timely. Staff are only required to handle exceptions.	MITA standard interfaces incorporate full HIPAA data schemas. Standard results use full functionality to convey program and benefit information. Member information is integrated via a Member Registry, which may either contain integrated records of member eligibility data or provide federated access to other Member Registries as appropriate. Sister agencies adopt MITA standard interfaces to present a one-stop shop for inquires regarding enrolled members.	Medicaid Member Registries are federated with RHIOs statewide so that authorized stakeholders can request member information. Requests are expanded to include inquiries re clinical information. For example, a provider can query a Member Registry about the location of needed clinical records anywhere in the state. Eligibility verification, program, benefit, and Member Registry health record locator services are integrated into applications such as EHRs and PHRs within RHIO(s) which enhances responses to inquiries regarding members.	Medicaid Member Registries are federated with RHIOs nationally. Providers can inquire about member health records in other states.
Business Capability Qualities: Timeliness of Process				
Most requests for verification of member information are received and responded to manually via phone, fax, USPS.	Member eligibility/enrollment verification is automated via AVRS, point of service devices, Web portal, EDI, but remains siloed. Responses	Responses can be immediate. Information can be shared among entities authorized by the Agency.	Responses are immediate. Information, including clinical, can be shared among authorized entities within the RHIO.	Turnaround time is immediate, on a national scale.

ME Inquire Member Eligibility: Business Capabilities

Inquire Member Eligibility Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	can be immediate.			
Data Access and Accuracy				
Information is researched manually. There may be inconsistencies in responses.	Automation improves access and accuracy. Access is via AVRS, point of service devices, Web portal, and EDI channels. Increased use of HIPAA eligibility/enrollment data but not the program and benefit data. Minimal use of these transactions for COB.	Member eligibility/enrollment, program, and benefit data and messaging formats adhere to MITA standard interfaces, improving verification, COB, reporting, and research accuracy. Member information is accessible from federated Member Registries within the state Enterprise.	Medicaid Member Registries are federated with RHIOs. All authorized data exchange partners can access member information.	Medicaid Member Registries are federated with regional data exchange networks across the country and if desired, internationally.
Effort to Perform; Efficiency				
Staff research and respond to requests manually. High rate of erroneous eligibility information. Verification takes effort and too much time for providers.	Responses to requests to verify member information are automated. Fewer staff required to support. Electronic verification is easier and faster, so providers use it more often.	Member information is continuously refreshed. One stop shop for programs that share members. Further reduction in staff support. Providers increasingly use verification because centralized registry gives them access to all Agency eligibility information including programs and benefits.	Access to clinical information can improve efficiency for treatment, payment and operations.	Automated access to information nationally further improves efficiency.
Cost-Effectiveness				
Requires research staff. Mailing id cards to members monthly is costly. Verification is too expensive for providers to use for each	Automation leads to fewer staff than Level 1. Number of responses per day increases significantly. Electronic verification lowers	Use of MITA standard interfaces increase cost-effectiveness. Because covered services are included in eligibility	Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who monitor	Gains of Level 4 are further improved by access to member information on a national basis.

ME Inquire Member Eligibility: Business Capabilities

Inquire Member Eligibility Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
encounter but providers risk cost of denied claims for ineligible members and non-covered services.	cost to providers and reduces denied claims for ineligible members and non-covered services.	verification responses, providers experience fewer claim denials based on non-covered services.	stakeholder satisfaction with responsiveness to inquiries. Regional, federated provider registries eliminate redundant overhead.	
Accuracy of Process Results				
Responses are manually validated, e.g., call center audits; stakeholder satisfaction survey. Process complies with agency requirements.	Automation improves accuracy of responses.	Business services standardize requests and responses nationally. More robust use of the HIPAA transactions increases accuracy.	Incorporation of clinical data improves accuracy of some responses.	Same as Level 4, on a national scale, where authorized.
Utility or Value to Stakeholders				
Requestors receive the information they need.	Providers have no delay in obtaining responses.	Providers have a one stop shop to access collaborating agencies to obtain information.	Some inquiries/responses are replaced by automated messaging.	Same as Level 4, on a national scale, where authorized.
Conformance Criteria for Each Level: (TBD)				

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ME Perform Population and Member Outreach: Business Capabilities[1]

Perform Population and Member Outreach				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the Perform Applicant and Member Outreach business process is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes. Outreach is primarily manual and conducted by paper or phone. Outreach materials are manually prepared and updated. Identification of targeted members is based primarily on member records and limited to current program information. Outreach to prospective members is sporadic and lacks analysis needed for targeting populations based on demographics, socio-economic status, functional and health needs. Current and prospective members have difficulty locating needed information because of siloed programs. Functionally, linguistically, culturally, and competency appropriate outreach and education materials are	At this level, the Perform Applicant and Member Outreach business process is more coordinated and populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socio-economic status, functional and health needs based on increased standardization of administrative data, and improved data manipulation for decision support. In addition to phone and paper, states use Websites, Agencies use TV, radio and advertisements to distribute outreach information to targeted members. Outreach material is functionally, linguistically, culturally, and competency appropriate, but at great expense. Outreach materials are developed and stored in electronic format and made available to members via a Web portal, public media, or	At this level, the Perform Applicant and Member Outreach business process is organized around the "no wrong door" concept, which ensures that regardless of outreach campaign, current and prospective members will be able to access information about all programs that member may be eligible to receive. This ensures agency-wide outreach coordination and greater ability to measure the efficacy of outreach. Agencies support deployment of internet access points, such as kiosks and low cost telecommunication devices such as cell phones for distribution to mobile communities, to alleviate communications barriers The business process is primarily electronic, with paper used only secondarily. Use of electronic communications makes provision of functionally, linguistically, culturally, and	At this level, the Perform Applicant and Member Outreach business process is part of customer relationship management, an "anticipatory" push of information needed by current and prospective members, decreasing their need to discover the information. Access to standardized electronic clinical data via registries, electronic prescribing, and electronic health records facilitates identification of and may trigger electronic messages to members in need of outreach and/or education about e.g., eligibility and care/disease management via email/EHRs/PHRs. Coordinated outreach and education can be regional and Pan-Medicaid in scope, based on analysis of clinical, demographic, and socio-economic indicators. Outreach material are automatically generated and sent to members in response	At this level, the Perform Applicant and Member Outreach business process is national in scope, based on analysis of clinical, demographic, and socio-economic indicators and shared among Medicaids and other public programs. Outreach triggers are event-driven. Peer2peer business process collaboration between the Agency and EHRs or other program applications, e.g., state Employment department system for tracking unemployed individuals, a PHR or EHR, trigger applications to collaboratively assist current and prospective members with outreach – e.g., pre-populating member data in an eligibility/enrollment application for an appropriate program and returning the determination/enrollment information in real time via the initiating application (No Wrong Application).

ME Perform Population and Member Outreach: Business Capabilities[1]

Perform Population and Member Outreach				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
lacking because difficult and costly to produce. Quality and consistency of outreach and education efforts are difficult to maintain. The agency may encounter obstacles to delivery, e.g., incorrect or lack of contact information.	kiosks, somewhat improving current and prospective members' ability to locate needed information.	competency appropriate outreach material more feasible and cost-effective. Access to standardized electronic clinical data via registries, electronic prescribing, claims and service review attachments and electronic health records, as well as use of GIS and socio-economic indicators support targeting populations for outreach. Member registries use standardized contact data, including NPS address standards, to alleviate postal delivery failures. Current and prospective members are easily able to access information regardless of their channel of inquiry or the program about which they need information (No Wrong Door). Outreach and education materials are available via state Medicaid portal and are shared with other collaborating agencies.	to requests made via email or PHRs, or by scheduled release. Staff focuses on maintaining a data base of functionally, linguistically, culturally, and competency appropriate outreach and education materials.	
Business Capability Qualities: Timeliness of Process				
This is primarily an all-manual process. "It takes the time it takes". Members must	Electronic storage and dissemination of member materials shortens the time to	Outreach and education information are immediately available to members across	Triggers create messages from members' EHRs/PHRs that map to automated	Turnaround time for triggering, sending appropriate information is

ME Perform Population and Member Outreach: Business Capabilities[1]

Perform Population and Member Outreach				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
wait in phone queue to make inquiries and may have to contact multiple programs to access the needed information. Mailings take a number of days to produce and send.	reach the members. Paper and non-routine outreach is still time-consuming. Access to electronic sources or outreach and education materials somewhat reduces time that current and prospective members must spend discovering needed information.	collaborating agencies. Greatly reduces time current and prospective members must spend discovering and submitting needed information.	response messages such as eligibility/enrollment application contained in an Outreach and Education database. Turnaround time to identify target member and transmit information is immediate. Nearly eliminates time current and prospective members must spend discovering and submitting needed information to the Agency.	immediate, on a national or regional scale. Nearly eliminates time current and prospective members must spend discovering and submitting needed information to all social services.
Data Access and Accuracy				
Preparation of materials is clunky. Information is subject to inaccuracies and inconsistencies. Lack of functionally, linguistically, culturally, and competency appropriate outreach and education materials likely limit members' access to information. Mailings are not delivered because contract data in members' records do not meet NPS standards.	Automation improves access and accuracy. Current and prospective members can access needed information via Web portal. Increased standardization of administrative data, and improved data manipulation for decision support improves accuracy of population targeting. Increasing use of functionally, linguistically, culturally, and competency appropriate outreach and education materials improve members' access to information.	Member information is accessed via federated Member Registries that can be accessed by all authorized entities within the state. Algorithmic identification of and analysis based on standardized data to targeted members improve in accuracy. Use of NPS standards for member data improves accuracy for mailing purposes.	Access to standardized clinical data facilitates identification of targeted current and prospective members. Standardized services support application interfaces for electronic interchange of outreach and education materials to targeted members.	Outreach and education materials can be effectively pushed on an as needed basis because of standardized data used by Member Registries nationally. Standardized business process collaboration protocols support application interfaces for peer2peer outreach and education processes.

ME Perform Population and Member Outreach: Business Capabilities[1]

Perform Population and Member Outreach				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Effort to Perform; Efficiency				
Staff develops and maintains materials manually. Developing functionally, linguistically, culturally, and competency appropriate outreach and education materials is difficult. As a result, more staff is required to assist members needing such material. Effort is required to research target current and prospective target populations and track mailings. Mailings are not delivered because of inaccurate, nonstandard contact information, resulting in need to follow up with members by other means or missing outreach and education opportunities.	Populations are targeted more effectively because programs are able to share analysis of current and prospective member demographics, socio-economic status, functional and health needs based on increased standardization of administrative data, and improved data manipulation for decision support. Materials can be posted on a Web site for downloading by members. Fewer staff required to support. Delivery of functionally, linguistically, culturally, and competency appropriate outreach and education materials is eased with electronic and public media channels.	National standards are developed for creation education and outreach materials. Business services are developed and shared nationally to support target population identification. Further reduction in staff required for this business process. Mailings are more successful because member records have NPS standard data and member registries' use algorithmic identification to improve data accuracy, reducing the need to follow up with members by other means or missing outreach and education opportunities.	Access to clinical information improves efficiency by automatically mapping member who needs assistance with generation of appropriate materials. Automated business rules that include clinical data lead to faster identification of target populations.	Outreach and education materials can be effectively pushed on an as needed basis regionally or nationally via federated Member Registries. The target population analysis based on real time access to health and socio-economic indicators drawn from standardized person/patient data.
Cost-Effectiveness				
Process is labor-intensive. Paper materials are expensive to produce. Incurs postal expenses and cost of undelivered mail. Staff still needed where the materials are not appropriate for member.	Automation reduces level of staffing required to target populations needing outreach and education. Availability of online materials reduces paper and mailing costs.	Collaboration, data sharing, and shared services increase cost-effectiveness. Predominant use of electronic and public media communication channels lowers cost of paper materials and improves	Full automation of the process of identification of need, mapping to the right message, plus access to clinical data reduces staff requirements to a core team of professionals who monitor the education and outreach	Outreach and education can be interoperable among states sharing business services, reducing redundant effort and optimizing delivery of appropriate needed material real time to the point of care.

ME Perform Population and Member Outreach: Business Capabilities[1]

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

[1] Optional.

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ME Manage Applicant and Member Communication: Business Capabilities[1]

Manage Applicant and Member Communication Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Member communications are primarily conducted via paper and phone. Member communications is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target populations; of inconsistent quality; not always linguistically, culturally or competency appropriate; may encounter obstacles to delivery, e.g., incorrect or lack of contact information. Requests are received from members in non-standard formats. Most requests are sent via telephone, fax, or USPS. Research is performed manually. Responses are inconsistent and manual. There may be delays in responses. Complies with agency goals and expectations. Requires signification labor force.	Member communications are primarily conducted via paper and phone. However, states begin using Websites to provide member information on providers and health plans, and responses to inquires that can be responded to online or by phone. Member communications are linguistically, culturally, and competency appropriate, but require considerable manual intervention for paper communications. Routine requests from members are standardized and automated within the agency via AVRS, Web portal, EDI. Research and response for these standardized communications are immediate or within batch response parameters. Responses are consistent and timely. Requires fewer staff.	Member communications are primarily electronic, with paper used only as needed to reach populations. Member communication is organized around the "no wrong door" concept, which ensures that regardless of point of entry, current and prospective members will be able to access information about all programs. This ensures agency-wide coordination and greater ability to measure the efficacy of member communications. Agencies support deployment of internet access points, such as kiosks and low cost telecommunication devices such as cell phones for distribution to mobile communities, to alleviate communications barriers. Use of electronic communications makes provision of linguistically, culturally, and competency appropriate member communications more	In addition to Level 3 gains, certain messages to members are triggered by an individual's entries into personal health records for prospective and current members. Information entered into provider electronic health records can also trigger specific messages to members regarding special programs and disease management information. Personal health records are available for free via the internet and accessible via kiosk and low cost telecommunication devices, such as cell phones and PDAs. Member Registry is federated with RHIOs so that other stakeholders can request member information to the extent authorized. Public health alerts can be triggered by clinical information in the patient's electronic health record.	Member communications posted by an agency can be accessed by a member anywhere in the country.

ME Manage Applicant and Member Communication: Business Capabilities[1]

Manage Applicant and Member Communication Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
		feasible and cost-effective. Member Registries use standardized contact data, including NPS address standards, to alleviate postal delivery failures. MITA standard interfaces (trigger event and results; messages to external entities), are used by Medicaid agency and collaborating sister agencies.		
Business Capability Qualities: Timeliness of Process				
Manual and semi-automated steps may require some days to complete response.	Member requests and responses are automated via Web, AVRS, EDI with date stamp and audit trail.	Inquiries can be made to multiple agencies via collaboration. Response can be immediate.	Turnaround time is immediate, including clinical data.	Turnaround time is immediate, on a national scale.
Data Access and Accuracy				
Responses are made manually and there may be inconsistency and inaccuracy (within agency tolerance level).	Automated responses increase accuracy. Access is via Web portal and EDI channels.	Requests and responses are standardized nationally, improving accuracy. Member information is accessed via either a single Member Registry or federated Member Registries. Member information belonging to different entities can be virtually consolidated to form a single view.	Member Registries are federated with regional data exchange networks, improving access channels. Responses are standardized and can include clinical data.	Member Registries are federated with regional data exchange networks across the country and if desired, internationally. Responses are immediately available.
Effort to Perform; Efficiency				
Staff research and respond	Responses to member	Information requested by	Access to clinical information	Automated access to

ME Manage Applicant and Member Communication: Business Capabilities[1]

Manage Applicant and Member Communication Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
to requests manually.	requests are automated. Fewer staff required to support.	member is continuously refreshed. Collaboration among agencies achieves a one-stop shop for member inquiries, e.g., mental health member requests claim payment status from Medicaid, Mental Health Department, Community Health Center.	improves efficiency.	information nationally further improves efficiency.
Cost-Effectiveness				
Requires research staff.	Automation leads to fewer staff than Level 1. Number of responses per day increases significantly.	Collaboration and shared services increase cost-effectiveness.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who monitor member satisfaction with responsiveness to inquiries.	Gains of Level 4 are further improved by access to member information on a national basis.
Accuracy of Process Results				
Responses are manually validated, e.g., call center audits; member satisfaction survey. Process complies with agency requirements.	Automation improves accuracy of responses.	MITA standard interfaces improve requests and responses nationally.	Incorporation of clinical data improves accuracy of some responses.	Same as Level 4, on a national scale, where authorized.
Utility or Value to Stakeholders				
Members receive the information they need.	Members have no delay in obtaining responses.	Members have a one stop shop to access collaborating agencies to obtain information.	Some inquiries/responses are replaced by automated messaging.	Same as Level 4, on a national scale, where authorized.

ME Manage Applicant and Member Communication: Business Capabilities[1]

Manage Applicant and Member Communication Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] (a.k.a. Member Relations) Includes requests, e.g., about benefits, programs, access to providers and health services.

ME Manage Member Grievance and Appeal: Business Capabilities [To Be Developed]

Manage Member Grievance and Appeal				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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Provider Management

PM Enroll Provider: Business Capabilities[1]

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Provider enrollment staff meet state and federal requirements for processing applications timely and accurately. Staff receive and process paper enrollment applications and manually apply the agency's business rules (including credentialing, verifying information, assigning ID, and associating rates) resulting in creating and maintaining a provider network that provides access to benefits for eligible members.	Provider enrollment staff receive and process paper and Web-based applications adhering to state Medicaid agency specific standards. Some business rules (e.g., verify information supplied, assign ID, associate rates, and map provider attributes to program needs, e.g., linguistic, specialty care) are automated. Some automated data exchange is established with credentialing organizations and ID sources. Improvements in processes result in creating and maintaining a provider network that complies with state and federal law and policy; meets members' clinical, cultural, and linguistic needs; and supports the needs of managed care and waiver programs. Providers are enrolled timely and accurately with additional data that match provider to patient needs, identify provider business relationships, and support	Provider enrollment staff continue to receive paper applications to support a minority of providers unable to use an automated process. The majority of applications are automated and will use MITA standard interfaces for receipt of the application (trigger event) and the automated result messages ("approved, denied, need more info"). [**NOTE:** the state-specific application interface at Level 2 is replaced by the MITA standard interface.] Most verification and validation of application information are automated. [Manual intervention is required on an exception basis.] MITA standard interfaces are used to validate credentials and verify or obtain ID numbers. Other agencies within the state collaborate with Medicaid to offer a one-stop shop to the applicant by	In addition to the improvements at Level 3, the enrollment process further benefits from automated access to federated registries that link to providers' clinical records. The additional clinical record information supplements information contained in the application and improves the validation processes. The clinical information is considered in validation of credentials, establishing taxonomy, and aligning the provider as a candidate for special programs, e.g., disease management, PCP. Messages are automatically sent to the special programs to consider enrollment of providers mapping to criteria.	The enrollment process has access to all provider registries nationally via data sharing and interoperability agreements resulting in optimizing the provider network through access to records re taxonomy, performance, quality, status. At Level 5, all enrollment application processes are automated; staff only handle exceptions. This frees staff to focus on professional oversight and consumer satisfaction. The National Health Information Network supports federated registries that identify providers across the country who are qualified to serve special populations or who are disqualified based on criminal activity.

PM Enroll Provider: Business Capabilities[1]

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	monitoring of delivery and quality of care). Staff perform queries into stored Medicaid provider and claims data to identify providers with specialties and service indicators indicating potential for enrollment as primary care, disease management, and waiver providers.	adopting the MITA standard interfaces. The combination of MITA standard interfaces shared by sister agencies within the state or clusters of border states and full automation of credentialing and other validations result in creating and maintaining a timely, robust, coordinated provider network. The NPI is the ID of record. Credentials are automatically re-validated and staff receive alerts when adverse results occur (e.g., provider license is terminated; provider is added to a criminal investigation list). These improvements help Medicaid program monitor the provider network. Through use of federated registries that link Medicaid and other agencies, Medicaid staff expands its ability to identify providers with special qualifications suitable for enrollment in programs that serve special populations. Members interact directly with providers and can view provider profiles and		

PM Enroll Provider: Business Capabilities[1]

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
		locations; make informed choices. Cultural and linguistic indicators improve selection of appropriate providers.		
Business Capability Qualities: Timeliness of Process				
Decisions on application may take several days but within State regulations.	Process is more timely than Level 1.	Turnaround time on application decision can be immediate.	Turnaround time is immediate including access to clinical data.	Turnaround time is immediate, on a national scale.
Data Access and Accuracy				
Application data and format are non standard. Some enrollment records are stored electronically but storage is not centralized. Provider data, including ID and taxonomy, is not comparable across provider types and programs, reducing ability to monitor performance or detect fraud and abuse.	Application data are standardized within the agency. Enrollment records for different programs are stored separately. Providers have different IDs per program and within Medicaid program and cannot be cross-matched. Although data comparability is improved, performance data is only periodically measured and requires sampling and statistical calculation.	Application data interfaces are standardized nationally using MITA standards. Enrollment records are stored in either a single Provider Registry or federated Provider Registries that can be accessed by all participants. The NPI is the identifier of record. Providers, members, and state enrollment staff have secure access to appropriate data on demand.	Medicaid Provider Registries are federated with regional data exchange networks. Authorized, authenticated parties have virtual, instant access to provider data locally. Access to clinical data improves capability to select providers that meet quality standards.	Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally. Authorized, authenticated parties have virtual, instant access to provider data, nationally.
Effort to Perform; Efficiency				
Staff contact external and internal credentialing and verification sources via phone, fax. A large staff is required to meet targets for manual enrollment of	Enrollment processes continue to be handled by siloed programs according to program-specific rules. Providers can submit on paper and electronically via a	Most applications are submitted electronically . Electronic applications adhere to MITA standard interface requirements. Medicaid and sister agencies	Any data exchange partner can send a notification regarding a provider enrolled with the state Medicaid program. External and internal	Any data exchange partner can send a notification regarding a provider enrolled with any program in the U.S. Nationally interoperable validation sources

PM Enroll Provider: Business Capabilities[1]

Enroll Provider Business Process: Includes providers of all types both new applicants and renewals				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
providers.	portal which improves turnaround time. Verifications are a mix of manual and automated steps.	collaborate on provider enrollment processes. Manual steps may continue only for exceptions.	validation sources automatically send notice of change in provider status, eliminating the need to re-verify; supports detection of sanctioned providers in real time.	automatically send notice of change in provider status, eliminating the need to re-verify; supports detection of sanctioned providers in real time anywhere in the U.S.
Cost-Effectiveness				
Requires large numbers of staff.	Process requires fewer staff than Level 1 and produces better results.	Process requires fewer staff than Level 2 and improves on results. Shared processes and inter-agency collaboration contribute to streamline the process.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who monitor provider network performance.	Same as Level 4 with additional benefit of access to sources of information nationally.
Accuracy of Process Results				
Much of the application information is manually validated. Decisions may be inconsistent. Due to limited monitoring and re-verification of enrolled providers' status, sanctioned providers may continue to be enrolled.[2]	Automation of some business rules improves accuracy of validation and verification. The emphasis on managed care and waiver programs encourages more scrutiny of and reporting to national databases.	All verifications can be automated and conducted via standardized interfaces. Consistent enrollment rules, standardized data available from a single source support continuous performance measures that can be used to adjust rates in real time. The agency sends verification inquiries to any other agency regarding the status of a provider. The quality of the provider network is improved.	Prospective monitoring of program integrity during adjudication improves detection of fraud and abuse, resulting in timelier sanctioning. Clinical data can be accessed and monitored for measuring performance. Performance measures can be shared via federated Provider Registries.	Same as Level 4, on a national scale. Performance measures can be shared via federated Provider Registries, nationally.

PM Enroll Provider: Business Capabilities[1]

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

[1] The Enroll Provider Business Process improves at Level 2 with use of Web based application submissions and automation of rules. Level 3 standardizes applicant input and output messages using MITA standard interfaces and supports collaboration among agencies, providing a one-stop shop for applications locally. Standard interfaces with credentialing organizations and ID sources add to the improvements. Level 4 supports access to clinical records to enhance the enrollment process. Level 5 creates a national reservoir of provider information that any participating enrollment entity can access.

[2] There is inconsistent reporting to National Provider Data Bank or to the HIPAA Health Integrity Protection Database.

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PM Disenroll Provider: Business Capabilities [To Be Developed]

Disenroll Provider				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PM Manage Provider Information: Business Capabilities[1]

Manage Provider Information: Maintain and update provider database				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Changes to provider registry are managed manually. Accuracy of data is manually verified. There is no single standard for data stored for different types of providers. Duplicate entries may go undetected. Notification to users re changes to registry is non-standard. Needs of various users of provider data are uncoordinated and may be unmet.	Changes to provider registry are standardized within the agency and automated. Validation of changed data is consistent. Updates are timely, e.g., within 24 hours. Changes are immediately available to users and business processes that need to use this information. NPI is introduced but is translated to local IDs.	MITA standard interfaces are used for changes to provider registry. These include the change (trigger event: new, changed, deleted information) and the response (result: change is accepted, not accepted, requires more information). Other agencies statewide can collaborate with Medicaid and accept the MITA standard interface. NPI is the ID of record and this standard is used by all downstream business processes.	The agency's provider registry is federated with statewide RHIOs . Information and changes re a provider are shared by all entities that contract with that provider. Provider registry information includes performance measures automatically communicated from the provider's clinical record.	The agency's provider registry is federated with statewide RHIOs and is connected to all other RHIOs and registries nationally through the NHIN.
Business Capability Qualities: Timeliness of Process				
Manual and semi-automated steps require some days to complete update and maintenance process.	Provider updates are automated with date stamp and audit trail.	Update can be immediate. Data exchange partners receive update information instantly.	Turnaround time is immediate. Updates are available to all data exchange partners.	Turnaround time is immediate, on a national scale.
Data Access and Accuracy				
Updates are made to data manually. Inconsistencies and inaccuracies can go undetected.	Automated updates are consistent according to agency standards.	Data conforms to MITA standard interfaces. Provider records are stored in either a single Provider Registry or federated Provider Registries that can be accessed by all users of provider data.	Medicaid Provider Registries are federated with regional data exchange networks. Information is accessible to all data exchange partners Clinical data is included in the data set.	Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally. Updates are immediately posted and accessible to all data exchange partners.

PM Manage Provider Information: Business Capabilities[1]

Manage Provider Information: Maintain and update provider database				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Effort to Perform; Efficiency				
Staff perform file updates manually.	Updates are automatically processed. Edits are consistent. Fewer staff required to support.	Updates are distributed to data sharing partners. One stop shop for entities who share providers. Further reduction in staff support.	Clinical data is used to trigger provider registry updates. For example, a provider registered with specialty A, demonstrates through the clinical record history that most diagnoses and service codes suggest specialty B. (State policy is required to permit an automated update of the provider registry to add specialty B).	Any data exchange partner can send a notification regarding a provider record update to any other program in the USA. Nationally interoperable validation sources automatically send notice of change in provider status, eliminating the need to re-verify. Supports detection of sanctioned providers in real time anywhere in the USA. Can be expanded to any other country to obtain information on an immigrant or guest provider.
Cost-Effectiveness				
Requires large data entry staff.	Automation leads to fewer staff than Level 1.	Distributed updates of changes to provider registry reduce staff requirements.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who monitor provider network performance. Regional, federated provider registries eliminate redundant overhead.	Gains of Level 4 are further improved by access to provider updates on a national basis.
Accuracy of Process Results				
Updates are manually	Automation improves	NPI is the ID of record and		

PM Manage Provider Information: Business Capabilities[1]

Manage Provider Information: Maintain and update provider database				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
validated. Process complies with agency requirements.	accuracy of validation and verification of database updates.	standardizes ID and taxonomy updates. Other changes are also standardized and shared across agencies.		
Utility or Value to Stakeholders				
Provider update information is maintained and available to other business processes.	In managed care and waiver settings, guidelines ensure adequacy of network (i.e., ratio of number, type, and location of provider to size and demographics of member population). Cultural and linguistic matches are made. Members are assigned to PCPs to coordinate their care. Automated maintenance of provider information ensures that timely, accurate data are available to support member assignment.	Members can view provider profiles and locations; make informed choices. Cultural and linguistic indicators improve selection of appropriate providers. Provider and member satisfaction improves because of speed and accuracy of enrollment process.	Providers, members, and care managers access standardized Provider Registries and view clinical performance indicators to make informed decisions re provider selection, provider referrals.	Same as Level 4, on a national scale, where authorized.
Conformance Criteria for Each Level: (TBD)				

[1] The Manage Provider Information Business Process is fully automated at Level 2 using Medicaid agency standards. At Level 3 changes to provider data are standardized using MITA interface specifications. At Level 4 clinical information is available and access to provider information is managed through a RHIO portal. At Level 5, RHIOs are linked through the NHIN and all provider information is available to any authorized entity, nationally.

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PM Inquire Provider Information: Business Capabilities[1]

Inquire Provider Information (a.k.a. Inquire re Provider Information)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Inquiries are received from different sources to obtain information about a provider (e.g., status, location, specialty, status) in non-standard formats. Most requests are sent via telephone, fax, or USPS. Research is performed manually. Responses are inconsistent and manual. There may be delays in responses. Complies with agency goals and expectations.	Routine inquiries for provider information are standardized and automated within the agency via AVRS, Web portal, EDI. Responses are immediate or within batch response parameters. Responses are consistent and timely. A reduced workforce is required to handle problems and direct telephone inquiries.	MITA standard interfaces are used for inquires regarding provider registry information. Other agencies statewide can adopt MITA standard interfaces and participate in the inquiry process. NPI is the ID of record used in the inquiry regarding provider information.	Provider registry is federated with RHIOs statewide so that any stakeholder can request provider information to the extent authorized. Pointers to selected clinical information are added to the provider registry data. For example, a provider can inquire about summary clinical records of hospitals, labs, or specialists before making a referral.	Provider registry is federated with RHIOs nationally so that any stakeholder can request provider information to the extent authorized anywhere in the country.
Business Capability Qualities: Timeliness of Process				
Most requests for verification of provider information are received and responded to manually via phone, fax, USPS.	Requests for provider information are automated via AVRS, Web portal, EDI within an agency using agency standards for messages. Responses to routine inquiries are immediate.	Responses are immediate. Information can be shared among authorized entities within the state.	Responses are immediate. Information, including clinical, can be shared among authorized entities within the state.	Turnaround time is immediate, on a national scale.
Data Access and Accuracy				
Information is researched manually. There may be inconsistencies in responses.	Automation improves access and accuracy. Access is via Web portal and EDI channels.	Data inquiry messages use MITA standard interfaces, improving accuracy. Collaborating agencies using the MITA standard interfaces	Medicaid Provider Registries are federated with regional data exchange networks. All authorized data exchange partners can access provider	Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally.

PM Inquire Provider Information: Business Capabilities[1]

Inquire Provider Information (a.k.a. Inquire re Provider Information)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
		can exchange data on registered providers.	information.	
Effort to Perform; Efficiency				
Staff research and respond to requests manually.	Responses to requests to inquire about provider information are automated. Fewer staff required to support.	Provider information is continuously refreshed. One stop shop for agencies who share providers. Further reduction in staff support.	Inquiries include summary clinical information relating to provider performance and quality of care.	Automated access to information nationally further improves efficiency.
Cost-Effectiveness				
Requires research staff.	Automation leads to fewer staff than Level 1. Number of responses per day increases significantly.	Use of MITA standard interfaces streamlines the inquiry process.	Regional, federated provider registries eliminate redundant overhead, i.e., one-stop shop inquiries.	Gains of Level 4 are further improved by access to provider information on a national basis.
Accuracy of Process Results				
Responses are manually validated, e.g., via call center audits; stakeholder satisfaction survey. Process complies with agency requirements.	Automation improves accuracy of responses.	MITA standard interfaces produce consistent responses to inquiries.	Incorporation of clinical data improves accuracy of some responses.	Same as Level 4, on a national scale, where authorized.
Utility or Value to Stakeholders				
Requesters receive the information they need.	Requesters receive immediate responses.	Requesters have a one-stop shop to access collaborating agencies to obtain information on a provider.	Requesters benefit from access to clinical data as an added value.	Same as Level 4, on a national scale, where authorized.

PM Inquire Provider Information: Business Capabilities[1]

Inquire Provider Information (a.k.a. Inquire re Provider Information)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] At Level 2, inquiries are standardized and automated via AVRS, Web portal, and EDI channels. At Level 3, input and output messages are standardized nationally and agencies share Verify Information business services. At Level 4, inquiries expand to include clinical information and at Level 5 provider information can be inquired about nationally.

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PM Manage Provider Communication: Business Capabilities[1]

Manage Provider Communication: (a.k.a. Provider Relations) Includes questions from the provider and agency answers (e.g., provider enrollment status, payment rules. Includes communication from the agency to targeted or all providers re policy, rules, new programs, and public health alerts.)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Requests are received from providers in non-standard formats. Most requests are sent via telephone, fax, or USPS. Research is performed manually. Responses are inconsistent and manual. There may be delays in responses. Complies with agency goals and expectations. Requires significant labor force. Provider communication is not coordinated among multiple, siloed programs and not systematically triggered by agency-wide processes. No emphasis on linguistic, cultural or competency-based considerations. May encounter obstacles to delivery, e.g., incorrect or lack of contact information.	Routine requests from providers are standardized and automated within the agency via AVRS, Web portal, EDI. Research and response for these standardized communications are immediate or within batch response parameters. Routine responses are consistent and timely and require fewer staff. Provider communications improve in meeting linguistic, cultural, and competency goals, but require labor intensive intervention. Routine communications are created to meet the needs of managed care, waiver, a-typical, and special program providers.	The majority of communications is automated. MITA standard interfaces are used for automated messages between provider and agency. These include the provider inquiry (trigger event) and the outbound response (result). Provides a one-stop shop for frequently asked questions for Medicaid and other collaborating agencies that accept the MITA standard interfaces. Communications are standardized within the Medicaid agency resulting in better coordination and greater ability to measure the efficacy of provider communications. Use of electronic communications makes provision of linguistically, culturally, and competency appropriate messages more feasible and cost-effective. Provider registries use standardized contact data,	Medicaid provider registry is federated with RHIOs which enables the Medicaid agency to reach all targeted providers statewide to receive general communiqués or public health alerts. All health care agencies are able to collaborate in sending and receiving communications between agencies and among all providers statewide. Many typical provider communications are handled directly by connectivity between the provider's clinical record system and the Medicaid agency. For example, if the provider enters information into the clinical record regarding the disease state of the patient, the Medicaid system can send information to the provider re candidacy of the patient for a disease management program.	Level 4 gains plus: Provider Registry is federated with RHIOs on a national scale. Requests can be received and responded to nationally and internationally. Messages can be sent from one state Medicaid to providers in other states depending on inter-agency agreements (e.g., regional health alerts). Indicator algorithms triggered by RHIO traffic, clinical record updates, and personal health record entries can trigger communication messages directly to the provider.

PM Manage Provider Communication: Business Capabilities[1]

Manage Provider Communication: (a.k.a. Provider Relations) Includes questions from the provider and agency answers (e.g., provider enrollment status, payment rules. Includes communication from the agency to targeted or all providers re policy, rules, new programs, and public health alerts.)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
		including NPI address standards, to alleviate postal delivery failures.		
Business Capability Qualities: Timeliness of Process				
Manual and semi-automated steps may require some days to complete response.	Provider requests and responses are automated via Web, AVRS, EDI with date stamp and audit trail.	Inquiries and responses using MITA standard interfaces are immediate.	Inquiry and response, and communications sent by the agency are immediate. Interaction between provider clinical data and the agency is automatic.	Turnaround time is immediate, on a national scale.
Data Access and Accuracy				
Responses are made manually and there may be inconsistency and inaccuracy (within agency tolerance level).	Automated responses increase accuracy. Access is via Web portal and EDI channels.	Requests and responses are standardized as MITA interfaces, improving accuracy. Provider information is accessed via either a single Provider Registry or federated Provider Registries. Provider information belonging to different entities can be virtually consolidated to form a single view.	Medicaid Provider Registries are federated with regional data exchange networks, improving access channels. Responses are standardized. The provider clinical record information can trigger messages to and from the provider and the Medicaid agency.	Medicaid Provider Registries are federated with regional data exchange networks across the country and if desired, internationally. Responses are immediately available.
Effort to Perform; Efficiency				
Staff research and respond to requests manually.	Responses to routine provider requests are automated. Fewer staff required to support.	Information requested by provider is continuously refreshed. Collaboration among agencies achieves a one-stop shop for provider inquiries, e.g., mental health	Access to clinical information can improve efficiency especially in alert messaging.	Automated access to information nationally further improves efficiency.

PM Manage Provider Communication: Business Capabilities[1]

Manage Provider Communication: (a.k.a. Provider Relations) Includes questions from the provider and agency answers (e.g., provider enrollment status, payment rules. Includes communication from the agency to targeted or all providers re policy, rules, new programs, and public health alerts.)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
		provider requests enrollment status from Medicaid, Mental Health Department, MCO.		
Cost-Effectiveness				
Requires large research staff.	Automation leads to fewer staff than Level 1. Number of responses per day increases significantly.	Use of MITA standards and collaboration among agencies increases effectiveness.	Full automation of the process plus access to clinical data reduces staff requirements to a core team of professionals who monitor provider satisfaction with responses to inquiries.	Gains of Level 4 are further improved by access to provider information on a national basis.
Accuracy of Process Results				
Responses are manually validated, e.g., call center audits; provider satisfaction survey. Process complies with agency requirements.	Automation improves accuracy of responses.	MITA standard interfaces specify requests and response messages and are used by collaborating agencies in the state.	Access to clinical data improves accuracy of targeted alerts.	Same as Level 4, on a national scale, where authorized.
Utility or Value to Stakeholders				
Providers receive the information they need.	Providers have no delay in obtaining responses.	Providers have a one stop shop to access collaborating agencies to obtain information.	Some inquiries/responses are replaced by automated messaging.	Same as Level 4, on a national scale, where authorized.
Conformance Criteria for Each Level: (TBD)				

[1] The Manage Provider Communication Business Process shows improvement at Level 2 through use of AVRS, Web portal, and EDI channels, and standardization of messages at the Medicaid agency level. At Level 3, MITA standard interfaces for request and response for common communications are used by collaborating agencies within a state. Level 4 and supports direct communication between agency and provider triggered by information added to the provider's records. Level 5 makes communications available nationally among collaborating agencies.

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PM Manage Provider Grievance & Appeal: Business Capabilities[1]

Manage Provider Grievance & Appeal				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
This is an all-manual process. Grievances and appeals are filed via fax and USPS. Requests for documents are managed manually. Confidential documents are transferred by certified mail. Verification of information is handled manually. The process is lengthy. There may be inconsistencies between cases of the same type.	Grievance and appeal cases are filed via USPS and fax. Documents are scanned and the case file is automated and can be shared among case workers. Some review steps are automated using agency-specific standards. Time required to develop the case is reduced. There is more consistency in the steps taken in the review and resolution process.	MITA standard interfaces are used for Grievance and Appeal triggers (grievance and appeal application data) and results (case resolution). MITA standard interfaces are used to initiate and develop the case, e.g., Request documentation; Validate credentials; Maintain case. Case file is Web-enabled; information is shared among staff managing the case. Medicaid collaborates with other health and human services agencies that manage appeals to create a one-stop shop model for both provider and consumer appeals.	Clinical data is automatically accessed to substantiate case findings. Automated business rules that include clinical data lead to earlier resolution of cases. The original case against a provider may be triggered directly from the clinical record.	Interoperability and data sharing agreements across states facilitate case resolution. For example, one state can view how other states have resolved similar cases; one state can determine if the provider is (or has been) involved in similar cases in other states.
Business Capability Qualities: Timeliness of Process				
This is an all-manual process. Cases typically require months to complete.	Requests for provider information are automated via AVRS, Web portal, EDI within an agency. Responses to research questions within the agency are immediate. Overall timeline to resolve a case is shortened.	Responses to research questions are immediate across all data sharing partners within the state.	Responses to research questions are immediate. Information, including clinical, is immediately and directly accessible.	Turnaround time of information gathering is immediate, on a national scale.
Data Access and Accuracy				
Information is researched	Automation improves access	Standard MITA interfaces	Medicaid Provider Registries	Medicaid Provider Registries

PM Manage Provider Grievance & Appeal: Business Capabilities[1]

Manage Provider Grievance & Appeal				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
manually. There may be inconsistencies in responses. There are no standards for case data.	and accuracy. Access is via Web portal and EDI channels. Agency standards for inquiries are introduced.	improve accuracy of content.	are federated with regional data exchange networks. All authorized data exchange partners can access provider information, including clinical data.	are federated with regional data exchange networks across the country and if desired, internationally.
Effort to Perform; Efficiency				
Staff research and maintain manually.	Responses to requests to verify provider case information are automated. Fewer staff required to support.	MITA standard interfaces standards are used for creation of a case and publication of results. MITA standard interfaces are also used for inquiry and response for acquisition of information needed to build the case. Further reduction in staff required for this business process.	Access to clinical information improves efficiency. Automated business rules that include clinical data lead to earlier resolution of cases. The original case against a provider may be triggered directly from the clinical record. This is a paradigm shift that introduces a new business process.	Automated access to information nationally further improves efficiency. Case researchers instantly know if there are case precedents in other states or agencies (a) for the provider in question, or (b) for similar types of cases.
Cost-Effectiveness				
Process is labor-intensive. Results take several months.	Automation of some research steps reduces level of staffing required to manage a case.	Collaboration with sister agencies that conduct appeals cases increases cost-effectiveness. Standardization of input and case results allows staff to focus on analytical activities.	Full automation of the process plus access to clinical data reduce staff requirements to a core team of professionals who monitor stakeholder satisfaction with responsiveness to inquiries. Regional, federated provider registries eliminate redundant overhead.	Gains of Level 4 are further improved by access to provider information on a national basis.
Accuracy of Process Results				
Terms of the settlement or results of the hearing are	Automation is introduced into the case management	MITA standard interface improves accuracy of case	Incorporation of clinical data improves accuracy of final	Gains of Level 4 are further improved by access to

PM Manage Provider Grievance & Appeal: Business Capabilities[1]

Manage Provider Grievance & Appeal				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
manually documented according to the administrative rules of the state. There may be inconsistencies between similar cases. Process complies with agency requirements.	process. Results are documented and recorded automatically and can be accessed and reviewed as needed.	results.	disposition of the case.	provider information on a national basis.
Utility or Value to Stakeholders				
Business process complies with agency and state requirements for a fair hearing and disposition.	The provider and the agency benefit from introduction of automation to speed up the case resolution.	Agencies benefit from introduction of MITA standard interfaces. Providers benefit from consistency and predictability of the process.	Use of clinical evidence reduces false positives and improves consistency of results.	Same as Level 4, on a national scale.
Conformance Criteria for Each Level: (TBD)				

[1] The Manage Provider Grievance & Appeal Business Process begins at Level 1 as a predominantly manual process requiring many months to process and resolve, and progresses through increased levels of automation and capabilities (Levels 2, 3). At Level 4 and 5 direct access to clinical data and information stored in other states shortens the case resolution time period and enhances information needed to make timely and consistent decisions.

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PM Perform Provider Outreach: Business Capabilities[1]

Perform Provider Outreach & Education: Includes both enrolled and non participating providers				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The ***Perform Provider Outreach and Education*** business process is primarily manual. Agencies use, TV, radio, posters for public transportation and community centers and clinics, and newspaper advertisements to distribute outreach and educational information to targeted providers. Identification of targeted enrolled providers is based on provider registry data and claims history. Outreach is uncoordinated among multiple, siloed programs. Linguistic and cultural sensitivity refinements are absent. Quality and consistency of outreach and education efforts are difficult to maintain. The agency may encounter obstacles to delivery, e.g., incorrect or lack of contact information. Outreach and education materials are manually	Increased use of agency standards for provider data improves identification of targeted, enrolled providers; and aids in identification of provider gaps in specialty, location, cultural and linguistic needs. Linguistically, culturally, and competency appropriate material requires significant manual intervention. Electronic outreach and educational materials are available to providers via a Web portal. Standard educational and policy information for enrolled providers is maintained electronically by the agency and is distributed to the providers via electronic media.	Automated translation and repositories of cultural and competency appropriate statements makes provision of appropriate outreach material more feasible and cost-effective. Use of GIS and socio-economic indicators support targeting providers for outreach. Provider registries use standardized contact data, including NPI address standards, to alleviate postal delivery failures. Outreach and education materials are available via state Medicaid portal and are shared with other collaborating agencies.	Provider clinical information can trigger outreach and educational material that are automatically generated and sent to the provider.	States can share provider outreach and education materials with other states.

PM Perform Provider Outreach: Business Capabilities[1]

Perform Provider Outreach & Education: Includes both enrolled and non participating providers				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
prepared and updated.				
Business Capability Qualities: Timeliness of Process				
This is primarily an all-manual process. "It takes the time it takes". Provider manuals are constantly revised and new pages are mailed to providers.	Electronic storage and dissemination of provider manual materials shortens the time to reach the provider. Non-routine outreach is still time-consuming.	Outreach and education information are immediately available to providers across collaborating agencies.	Triggers create messages from provider clinical records that map to automated response messages contained in an Outreach and Education database. Turnaround time to identify target provide and transmit information is immediate.	Turnaround time for triggering, sending appropriate information is immediate, on a national scale (but probably will be used by regional groupings of states). CMS can send NPI and PDP messages to all providers via federated registries.
Data Access and Accuracy				
Preparation of materials is clunky. Information is subject to inaccuracies and inconsistencies.	Automation improves access and accuracy. Access is via Web portal for outreach material and via electronic media for routine information distributed to enrolled providers.	Provider information is accessed via federated Provider Registries that can be accessed by all authorized entities within the state. Identification of targeted providers and dissemination of information improve in accuracy.	Medicaid Provider Registries are federated with regional data exchange networks. Access to clinical data facilitates identification of targeted providers and focuses the outreach or education message.	Medicaid Provider Registries are federated with regional data exchange networks across the country.
Effort to Perform; Efficiency				
Staff develop and maintain materials manually. Effort is required to research target provider population and track mailings.	Materials can be posted on a Web site for downloading by providers. Fewer staff required to support.	Easier to identify target population and disseminate appropriate information.	Access to clinical information improves efficiency by automatically mapping provider who needs assistance with generation of appropriate materials. Automated business rules that include clinical data lead to faster identification of	Outreach and education can be interoperable among states sharing business services.

PM Perform Provider Outreach: Business Capabilities[1]

Perform Provider Outreach & Education: Includes both enrolled and non participating providers				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
			target list.	
Cost-Effectiveness				
Process is labor-intensive. Incurs postal expense.	Automation reduces level of staffing required to perform outreach and education.	Easier to identify target population and disseminate appropriate information.	Full automation of the process of identification of need, mapping to the right message, plus access to clinical data reduces staff requirements to a core team of professionals who monitor the education and outreach process. Regional, federated provider registries eliminate redundant overhead in locating addresses.	Outreach and education can be interoperable among states sharing MITA standard interfaces.
Accuracy of Process Results				
Difficult to determine impact of outreach and education. Studies are conducted to see if there are improvements in provider performance associated with outreach and education.	Use of portal by providers is monitored to ensure that all are actively engaged in downloading information. Agency can target providers who are not accessing information.	Easier to target provider populations and disseminate information appropriate to the needs.	Incorporation of clinical data improves accuracy of identification of targeted providers and dissemination of appropriate messages. Provider registries improve accuracy of contact information.	Gains of Level 4 are further improved by access to provider information on a regional or national basis.
Utility or Value to Stakeholders				
Business process complies with agency and state requirements for educating the provider network regarding rules and regulations and how to communicate with the agency.	The provider and the agency benefit from introduction of automation to speed up the outreach and education process.	Agencies benefit from sharing of information with other agencies. Providers benefit from consistency and timeliness of the information transmitted.	Outreach and education communications can be triggered by automated messaging. Use of clinical evidence creates better target groups and improves consistency of results.	Same as Level 4, on a regional or national scale.

PM Perform Provider Outreach: Business Capabilities[1]

Perform Provider Outreach & Education: Includes both enrolled and non participating providers				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] The Perform Provider Outreach & Education Business Process begins at Level 1 as a predominantly manual process requiring significant manpower, and progresses through increased levels of automation and capabilities (Levels 2, 3). At Level 4 and 5, new capabilities are introduced through access to clinical information and outreach to providers in other states.

Contractor Management

CM1 Manage Health Services Contract: Business Capabilities

Manage Health Services Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Manage Health Services Contract*** business process is likely primarily paper/phone/fax based processing and some proprietary EDI. Timeliness of responses to inquiries and data reporting is indeterminate.	At this level, the ***Manage Health Services Contract*** business process is increasing its use of electronic interchange. Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data. Centralization increases consistency of communications.	At this level the ***Manage Health Services Contract*** business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. Data is standardized for automated electronic interchanges. Communications are consistent, timely and appropriate.	At this level, the ***Manage Health Services Contract*** business process interfaces with other processes via federated architectures.	At this level, the ***Manage Health Services Contract*** business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

CM1 Manage Health Services Contract: Business Capabilities

Manage Health Services Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

CM1 Award Health Services Contract: Business Capabilities

Award Health Services Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Indeterminate format for proposal data. Much of the information is manually validated. Staff contact external and internal document verification sources via phone, fax. Decisions may be inconsistent. Requires large numbers of staff. Decisions may take several days.	Application data are standardized within the state. Contractors can submit applications via a portal. Verifications are a mix of manual and automated steps. Consistency is improved. Requires fewer staff. Process takes less time than Level 1.	Application data are standardized nationally. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate. Services will created for the following steps and can be shared. 1. Verify Credentials 2. Verify ID 3. Assign ID 4. Assign Rates 5. Negotiate Contract	Level 3 capabilities augmented by some new capabilities. External and internal validation sources automatically send notice of change in contractor status. Recertification notices are automatically generated. Clinical data, if useful in processing the enrollment request is accessible by direct access. Manual steps only required for exception handling.	Level 3 and 4 capabilities augmented by national interoperability, permitting the enrollment process to send inquiries to any other agency, state, federal, or other entities regarding the status of a contractor. Any data exchange partner can send a notification regarding a contractor enrolled with the state Medicaid program.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				

CM1 Award Health Services Contract: Business Capabilities

Award Health Services Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

CM1 Close out Health Services Contract: Business Capabilities

Close out Health Services Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Close out Health Services Contract*** business process has: ■ Indeterminate connectivity to client ■ Inconsistent timing for response to primary client ■ Multiple data formats and semantics ■ External inputs & outputs are received/sent manually via paper, telephone, & fax ■ Transactions are individually reviewed using inconsistent interpretation of guidelines responded to via paper/USPD or fax	At this level, the ***Close out Health Services Contract*** business process: ■ Improves on Level 1 capability plus by: ■ Point-to-point or wrapped connectivity to client ■ Point-to-point interfaces (trading partner agreements) segregated by interface type ■ Enhanced consistent timing for response to primary client ■ Different interfaces with different data format and semantics ■ Transactions are received and responded to via EDI, Web Portal Use of electronic Claim Attachment for Adjudication.	At this level, the ***Close out Health Services Contract*** business process: ■ Improves on Level 3 capability plus: ■ Virtual access to administrative and clinical records ■ Increased use of clinical data ■ Focused data – data of record ■ Use of metadata ■ Self adjusting business rules ■ Use of clinical data to increase the accuracy of processes ■ Clinical staff focuses on exception cases ■ Members empowered to make own treatment decisions	At this level, the ***Close out Health Services Contract*** business process: ■ Incorporates Level 3 capability plus ■ Virtual records ■ Use of clinical data ■ Focused data – data of record ■ Use of metadata ■ Self adjusting business rules ■ Use of clinical data to increase the accuracy of processes ■ Clinical staff focuses on exception cases. Members empowered to make own treatment decisions	At this level, the ***Close out Health Services Contract*** business process: ■ Improves on Level 4 capability plus: ■ Point-to-point collaboration ■ Content sensitive business logic ■ Business Process Management ■ Metadata – Shared nationally ■ Full interoperability with other local, state, and federal programs to provide complete virtual patient clinical record and administrative data ■ Access to national clinical guidelines ■ Most services instantly authorized or denied from point of service; payment automatically established without need of invoice
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				

CM1 Close out Health Services Contract: Business Capabilities

Close out Health Services Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

CM2 Manage Administrative Contract: Business Capabilities

Manage Administrative Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Monitor Administrative Services Contract*** business process uses indeterminate format for application data. Much of the information is manually validated. Staff contact external and internal document verification sources via phone, fax. Decisions may be inconsistent. Requires large numbers of staff. Decisions may take several days.	At this level, the ***Monitor Administrative Services Contract*** business process uses application data that is standardized within the state. Contractors can submit applications via a portal. Verifications are a mix of manual and automated steps. Consistency is improved. Requires fewer staff. Process takes less time than Level 1.	At this level, the ***Monitor Administrative Services Contract*** uses application data that is standardized nationally. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate. Services created for the following steps and can be shared. 1. Verify Credentials 2. Verify ID 3. Assign ID 4. Assign Rates 5. Negotiate Contract	At this level, the ***Monitor Administrative Services Contract*** business process interfaces with other processes via federated architectures.	At this level, the ***Monitor Administrative Services Contract*** business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				

CM2 Manage Administrative Contract: Business Capabilities

Manage Administrative Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

CM2 Award Administrative Contract: Business Capabilities

Award Administrative Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Manage Administrative Contracts*** business process uses indeterminate format for application data. Much of the information is manually validated. Staff contact external and internal document verification sources via phone, fax. Decisions may be inconsistent. Requires large numbers of staff. Decisions may take several days.	At this level, the ***Manage Administrative Contract*** business process uses application data that is standardized within the state. Contractors can submit applications via a portal. Verifications are a mix of manual and automated steps. Consistency is improved. Requires fewer staff. Process takes less time than Level 1.	At this level, the ***Manage Administrative Contract*** uses application data that is standardized nationally. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate. Services for the following steps and can be shared. 1. Verify Credentials 2. Verify ID 3. Assign ID 4. Assign Rates 5. Negotiate Contract	At this level, the ***Manage Administrative Contract*** business process interfaces with other processes via federated architectures.	At this level, the ***Manage Administrative Contract*** business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				

CM2 Award Administrative Contract: Business Capabilities

Award Administrative Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

CM2 Close out Administrative Contract: Business Capabilities

Close out Administrative Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level the ***Close-Out Administrative Contract*** business process uses indeterminate connectivity to client. Internal and external inputs and outputs are received or sent manually via paper, telephone and fax. Decisions may be inconsistent. Requires large numbers of staff. Inconsistent timing for response to primary client.	At this level, the ***Close-Out Administrative Contract*** business process is beginning to use electronic interchange and standardized application data within the state. Contractors can submit applications via a portal. Verifications are a mix of manual and automated steps. Consistency is improved. Requires fewer staff. Process takes less time than Level 1.	At this level, the ***Close-Out Administrative Contract*** business process has almost eliminated its use of non-electronic interchange and uses application data that is standardized nationally. All verifications can be automated. Rules are consistently applied. Decisions are uniform. Some manual steps may continue. Turnaround time can be immediate.	At this level, the ***Close-Out Administrative Contract*** business process interfaces with other processes via federated architectures.	At this level, the ***Close-Out Administrative Contract*** business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

CM2 Close out Administrative Contract: Business Capabilities

Close out Administrative Contract				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

CM3 Manage Contractor Information: Business Capabilities

Manage Contractor Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Requests are received from disparate sources in indeterminate formats. Validation is inconsistent and not rules-based. There are delays in completing updates. Duplicate entries may go undetected. Irregular notification of change to users and processes that need to know.	Requests are standardized and automated. Validation is consistent. Updates are timelier. More automation of rules to maintain integrity of data repository. Change is immediately available to users and processes that need to know.	Determinate interfaces (trigger event and results; messages to external entities), standardized data, consistent business rules and decisions, easy to change business logic. Manage Contractor Information is handled by a business service.	Level 4 is (TBD)	Level 5 is (TBD)
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

CM3 Manage Contractor Information: Business Capabilities

Manage Contractor Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

CM3 Inquire Contractor Information (TBD)

Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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CM4 Perform Potential Contractor Outreach: Business Capabilities

Perform Potential Contractor Outreach				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Perform Potential Contractor Outreach*** process is primarily conducted via paper and phone. Outreach is likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target populations; of inconsistent quality; may encounter obstacles to delivery, e.g., incorrect or lack of contact information.	At this level, the ***Perform Potential Contractor Outreach*** process primarily conducted via paper and phone. However, states use Websites, TV, radio and advertisements to distribute information to targeted contractors. Outreach may be more coordinated because programs are able to share analysis/ performance measures based on increase standardization of administrative data, somewhat standardized clinical data available via registries, and improved data manipulation for decision support. Program quality improvement initiatives are promoting more sophisticated performance measures that provide clinical and administrative indicators of populations needed to target outreach to contractors to ensure population health and access, but at great expense.	At this level, the ***Perform Potential Contractor Outreach*** process is primarily electronic, with paper used only secondarily. Outreach is centralized which ensures that regardless of outreach campaign, current and prospective providers will be able to access information. This ensures agency-wide outreach coordination and greater ability to measure the efficacy of outreach. Use of electronic communications makes outreach material more feasible and cost-effective. Access to standardized electronic clinical data via registries, electronic prescribing, claims and service review attachments and electronic health records, as well as use of GIS and socio-economic indicators, which provide basis for policy directives, support targeting contractors for outreach. Contractor registries use standardized contact data, including NPS address	At this level, the ***Perform Potential Contractor Outreach*** process may include automated targeting of providers via RHIO, PHRs and EHRs based on analysis of performance and business activity monitoring of state administrative, clinical and demographic data, and their resulting policy directives.	At this level, ***Perform Potential Contractor Outreach*** process may include collaborative discernment of individual contractor entities or organizations to whom outreach communications should be sent based on indicator algorithms that trigger during business activity monitoring at the agency, in the RHIO, EHRs, and the individuals' PHR.

CM4 Perform Potential Contractor Outreach: Business Capabilities

Perform Potential Contractor Outreach				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
		standards, to alleviate postal delivery failures.		
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

CM4 Manage Contractor Communication: Business Capabilities

Manage Contractor Communication				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Manage Contractor Communication*** process is primarily conducted via paper and phone. Contractor communications are likely uncoordinated among multiple, siloed programs and not systematically triggered by agency-wide processes; lacks data to appropriately target contractors, may encounter obstacles to delivery, e.g., incorrect or lack of contact information. Responses may be untimely, inconsistent and is labor intensive.	At this level, the ***Manage Contractor Communication*** process contractor communications are primarily conducted via paper and phone. However, states begin using Websites to provide contractor information, and accept inquiries that can be responded to online or by phone. Contractor communications processes begin to be centralized to achieve economies of scale. Despite some progress many responses continue to be untimely and labor intensive.	At this level, the ***Manage Contractor Communication*** process contractor communications are primarily electronic, with paper used only secondarily. Communications are centralized ensuring agency-wide coordination and greater ability to measure the efficacy of provider communications. Contractor registries use standardized contact data, including NPS address standards, to alleviate postal delivery failures.	At this level, the ***Manage Contractor Communication*** process Level 4 may include support for contractor communications via PHRs for prospective and current members. Clinical data may be incorporated into communications to improve quality of information and include medical outcomes and results.	At this level, the ***Manage Contractor Communication*** process Level 5 may support collaborative discernment of communication needs of prospective and current contractors via PHRs. Interoperability and data sharing agreements among states will facilitate contractor communications across state lines.
Business Capability Qualities: Timeliness of Process (TBD) (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				

CM4 Manage Contractor Communication: Business Capabilities

Manage Contractor Communication				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

CM4 Support Contractor Grievance and Appeal: Business Capabilities

Support Contractor Grievance and Appeal				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Support Contractor Grievance & Appeal*** process is entirely paper based, which results in poor document management and process inefficiencies that impact timeliness. Grievances and appeals are filed, managed, and resolved by siloed programs, leading to inconsistent application or relevant laws and administrative policies and inhibiting performance monitoring. Providers may have difficulty: ■ Finding the "Right Door" for filing grievances and appeals ■ Accessing program rules to discern the merit of their grievance or appeal ■ Getting assistance on their case or providing additional information ■ Receiving consistent responses or communications that are linguistically, culturally and competency appropriate	At this level, the ***Support Contractor Grievance & Appeal*** process conducts much of its business electronically, except where paper documents are required by law, which are OCR'd for electronic data capture. Agencies begin to centralize or standardize the administration of this process to achieve economies of scale, thereby increasing coordination and improving consistency by which rules are applied. and appeals disposed. Communications are more consistent. Contractors have limited access to program rules to discern whether their grievances or appeals have merit. Initial review and information gathering must be conducted by phone or in person. These changes improve process timeliness, document management, and supports business activity	At this level, the ***Support Contractor Grievance & Appeal*** process continues to conduct most of its business electronically, except where paper documents are required by law, which are OCR'd for electronic data capture. Access to administrative data needed to review and dispose of the grievances and appeals is readily available and standardized, improving consistency and timeliness of dispositions. However, clinical data is still paper-based and difficult to access in a timely manner. The process is administered as part of the Medicaid enterprise. As a result: ■ Contractors can electronically access program rules to discern whether their grievances or appeals have merit. Initial review and information gathering can be conducted electronically via phone and email.	At this level, the ***Support Contractor Grievance & Appeal*** process is able to interface with RHIOs to access standardized clinical data needed for review and disposition of grievances and appeals with utmost timeliness. Analysis of business rules to which the agency must adhere is automated, improving review turn around and consistency. *Program Quality Management* is better able to apply performance measures and focus business activity monitoring on operational data to detect opportunities for process, provider and contractor improvements to alleviate issues that give rise to grievances and appeals. Providers can access program rules to discern whether their grievances or appeals have merit. Initial review and information gathering can be conducted electronically via PHRs.	At this level, the ***Support Contractor Grievance & Appeal*** process enables contractors to file grievances and appeals in a collaborative environment via PHRs and EHRs in which the relevant administrative and clinical details is reviewed automatically and a preliminary disposition is made that can be raised for further evaluation by a reviewer. This optimizes resources, timeliness, and disposition consistency.

CM4 Support Contractor Grievance and Appeal: Business Capabilities

Support Contractor Grievance and Appeal				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	monitoring of performance measures, which in turn may provide data needed for process improvements.	■ Communications are consistent and timely. The process supports the ***Program Quality Management*** Business Area by providing data about the types of: grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities that may reduce the issues that give rise to grievances and appeals.		
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

CM4 Support Contractor Grievance and Appeal: Business Capabilities

Support Contractor Grievance and Appeal				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

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Operations Management

OM1 Authorize Treatment Plan: Business Capabilities

Authorize Treatment Plan				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Authorize Treatment Plan*** process is performed primarily using a paper/phone/fax process. Review of authorization of treatment plan requests are performed manually which is resource intensive, untimely and may result in inconsistent: ■ Application of business rules ■ Communication of errors to providers ■ Decisions on the need for or sufficiency of additional information If the treatment plan request requires additional information, the reviewer must manually contact the submitter/provider, which delays processing and is resource intensive. Format and content is not standardized and is likely state-specific. The requests are primarily manually validated against state-specific business rules. However, when there is automated validation, rules	At this level, the ***Authorize Treatment Plan*** process is a mix of paper/phone/fax and EDI. The authorize treatment plan requests may be accepted by internet Web portals, email, dial-up, and via transferable electronic media such as disks and tape. This increases the number of small providers who can submit requests electronically. If a treatment plan data set fails review, rather than the reviewer having to manually contact the submitter, the process can now generate an electronic request for additional information via an X12 277.	At this level, the ***Authorize Treatment Plan*** process transaction receives only EDI transactions via electronic means that support even small, rural, and waiver providers. Web portals support error free submissions with data field masks, client-side edits, and pre-populated fields. Standardized data enable tracking of over-utilization of similar services that are coded differently for prospective program integrity and tracking contraindication of services provided for medical appropriateness.	At this level, the ***Authorize Treatment Plan*** process queries national and regional registries for pointers to repositories of member's EHRs for clinical data and provider credentialing and sanction data for prospective program integrity audits. This data takes the form of virtual records. Meta-data is used to locate the records and to ensure semantic interoperability of the data even where the data may be based on different coding schemes or data models. Real-time access to source data ensures accuracy and improves process performance. This also enables enhanced business activity monitoring is based on optimal data streams to fine-tune business process rules to meet operational parameters, thereby ensuring that Agency objectives are met.	At this level, the ***Authorize Treatment Plan*** process is a simplified process. Inter-enterprise business process management between Medicaid systems and Clinical data during an episode of care eliminates the need for providers to submit treatment plan data. Through peer-to-peer collaboration, member and provider data accessible in regional registries are recognized by all participating applications as the "source of truth" – eliminating the necessity for the provider to send this information and for the Audit process to validate against its version of the information; the assists the provider with medical necessity protocols required by Medicaid and other payers' payment rules. Treatment plans for claims no longer needs to be checked because Medicaid business rules alert the provider about clinical prerequisites for service

OM1 Authorize Treatment Plan: Business Capabilities

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

OM1 Authorize Treatment Plan: Business Capabilities

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

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OM1 Authorize Referral: Business Capabilities

Authorize Referral				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Authorize Referral Request*** process is performed primarily using a paper/phone/fax process. Review of authorization requests are performed manually which is resource intensive, untimely and may result in inconsistent: ■ Application of business rules ■ Communication of errors to providers ■ Decisions on the need for or sufficiency of additional information If the referral request requires additional information, the reviewer must manually contact the submitter/provider, which delays processing and is resource intensive. Format and content is not HIPAA compliant, and is likely state-specific. The service requests are primarily manually validated against state-specific business rules. However, when there is automated validation, rules lack flexibility	At this level, the ***Authorize Referral*** process is a mix of paper/phone/fax and EDI. The service requests may be accepted by internet Web portals, email, dial-up, and via transferable electronic media such as disks and tape. This increases the number of small providers who can submit authorization requests electronically. If a referral data set fails review, rather than the reviewer having to manually contact the submitter, the process can now generate an electronic request for additional information via an X12 277.	At this level, the **Authorize Referral** process transaction, receives only EDI transactions via electronic means that support even small, rural, and waiver providers. Web portals support error free submissions with data field masks, client-side edits, and pre-populated fields. Standardized data enable tracking of over-utilization of similar services that are coded differently for prospective program integrity and tracking contraindication of services provided for medical appropriateness.	At this level, the ***Authorize Referral*** process queries national and regional registries for pointers to repositories of member's clinical data and provider credentialing and sanction data for prospective program integrity audits. This data takes the form of virtual records. Meta-data is used to locate the records and to ensure semantic interoperability of the data even where the data may be based on different coding schemes or data models. Real-time access to source data ensures accuracy and improves process performance. This also enables enhanced business activity monitoring is based on optimal data streams to fine-tune business process rules to meet operational parameters, thereby ensuring that Agency objectives are met.	At this level, the ***Authorize Referral*** process is a simplified process. Inter-enterprise business process management between Medicaid systems and Clinical data during an episode of care eliminates the need for providers to submit referral data. Through peer-to-peer collaboration, member and provider data accessible in regional registries are recognized by all participating applications as the "source of truth" – eliminating the necessity for the provider to send this information and for the Audit process to validate against its version of the information; the CLINICAL DATA assists the provider with medical necessity protocols required by Medicaid and other payers' payment rules. Service referrals for claims no longer needs to be checked because Medicaid business rules alert the provider about clinical

OM1 Authorize Referral: Business Capabilities

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

OM1 Authorize Referral: Business Capabilities

Authorize Referral				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
authorization process do not result in unintended cross-process consequences. Maintenance is expensive and time-consuming.				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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OM1 Authorize Service: Business Capabilities[1]

Authorize Service; Referral; and Treatment Plan (Authorize Service)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Authorize Service request is primarily paper, phone or fax based. Format and content are not HIPAA compliant. Each state has developed many paper forms to support this process. Information is manually validated and manually transferred from submitted paper to the MMIS. If a Authorize Service request requires additional information, the reviewer must manually contact the submitter/provider, which delays processing and is resource intensive. Authorize Service requests are primarily manually validated against state-specific business rules. As a result, states may conduct Authorize Service retrospectively as an audit, missing opportunities to ensure appropriate use of services. Inflexibility in Authorize Service processing is a key factor in the proliferation of siloed systems outside of the MMIS, especially for waiver	Authorize Service request is a mix of paper/phone/fax and EDI. Requests may be accepted by internet Web portals, email, dial-up, and via transferable electronic media such as disks and tape. This increases the number of small providers who can submit Authorize Service requests electronically. Authorize Service processes generate an electronic request for additional information via an X12 277 if additional information is required. Only unstructured paper forms are used in a manual review process, so inconsistent interpretation and application of Authorize Service rules persist. The increasing centralization of business processes promotes harmonized rules across some silos. The Authorize Service requests are increasingly compliant with HIPAA. However, HIPAA companion	The Agency receives EDI transactions via electronic means that support even small, rural, and waiver providers. Web portals support error free submissions with data field masks, client-side edits, and pre-populated fields, thereby eliminating the need for these submissions to go through manual validation. The Authorize Service process is completely automated and only rare exceptions must be manually reviewed. Optimizing automation improves error rates and timeliness, thereby enabling support of real-time processing. Authorize Service processing is highly flexible so that rule changes can be made quickly and inexpensively n response to need for new or different rules. Authorize Service process uses complex algorithms and the application of structured clinical data so that both prospective program integrity	Service authorization is embedded in the provider to payer system communication. As the provider enters service data into the CLINICAL DATA, authorization is immediately established by the payer application. The Medicaid agency and providers establish pointers to repositories of member's clinical data. This data takes the form of virtual records used to inform the Authorize Service process. Direct access to Clinical data eliminates the need for additional information within the Authorize Service process. Meta-data is used to locate the records and to ensure semantic interoperability of the data even where the data may be based on different coding schemes or data models. This data takes the form of virtual records used to inform the Authorize Service process.	Same capabilities as Level 4 expanded to a national base of data via the NHIN. The Authorize Service process queries national registries for pointers to repositories of member's clinical data stored anywhere in the country.

OM1 Authorize Service: Business Capabilities[1]

Authorize Service; Referral; and Treatment Plan (Authorize Service)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
programs that determine medical appropriateness and service authorization differently than traditional Medicaid programs. As a result, data is not comparable across silos. Since these systems duplicate MMIS capabilities and do not meet current MMIS requirements, states lose development, design, and implementation as well as operational federal funding participation (FFP).	guides may still require data based on state-specific business rules. Waiver Authorize Service data continue to be submitted to siloed payment systems using state specific format and data, such as provider type and service codes. As a result, data continues to lack comparability across silos. Despite progress, related processes continue to be tightly integrated, resulting in difficulty in making changes to business rules. Maintenance continues to be expensive and time-consuming.	and medical appropriateness can be highly automated, improving the consistency and correctness of the decisions. All programs, even those, such as waiver programs that are not covered under HIPAA, use semantically interoperable data in the process. Standardized data and Authorize Service rules enable tracking of over-utilization of similar services that are coded differently for prospective program integrity and tracking contraindication of services provided for medical appropriateness. As a result, all siloed payment systems are integrated; saving resources and optimizing FFP; and data quality is improved. Related processes are de-coupled, allowing changes to be made in the Authorize Service process with reduced potential for unintended downstream processing consequences.	The Authorize Service process is an inter-enterprise business process between Medicaid systems and Clinical data during an episode of care eliminating the need for providers to submit Authorize Service requests or supporting clinical data. Through peer-to-peer collaboration, the CLINICAL DATA assists the provider with Medicaid clinical protocols required for coverage, such as diagnoses, functional or health status, or clinical test results. Preconditions for achieving this level are use of established RHIOs and semantic interoperability.	
Business Capability Qualities: Timeliness of Process (TBD)				

OM1 Authorize Service: Business Capabilities[1]

Authorize Service; Referral; and Treatment Plan (Authorize Service)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

[1] Level 1 is primarily a manual process. Level 2 automates the receipt of and response to the request which speeds up turnaround time and introduces consistency into the data to be review. At Level 3, collaborating agencies use MITA standard interfaces and rules are automated. At Level 4, the Authorize Service process is entirely new (paradigm shift). The provider no longer submits a request; the provider's updated CLINICAL DATA sends a message to the agency regarding a new service. The agency's system responds instantly. Any needed clinical information is also immediately available. At Level 5, the Level 4 capability is extended to a national base of data.

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OM2 Edit and Audit Claim/Encounter: Business Capabilities[1]

Edit and Audit Claim/Encounter				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The agency receives paper claims, EDI transactions, and POS conforming to state standards. Paper transactions are batched and scanned (or data entered). State-specified data elements trigger the Edit and Audit Claim/Encounter business process.	The agency continues to accept paper claims, but most providers submit claims via Web portals, email, dial-up, POS, and EDI. Electronic transactions meet HIPAA data standards. Payer Implementation Guides impose additional payer-specific rules. Translators convert national data standards to state-specific data to support business processes.	The agency continues to accept paper claims from a small number of disadvantaged providers, but the majority of transactions are submitted electronically. Electronic transactions meet MITA standard interfaces. Payer-specific Implementation Guides are replaced by MITA standards. The Edit and Audit Claim/ Encounter business process uses MITA standard data and therefore no translation is required.	Direct connection between Medicaid systems and providers' Clinical data during an episode of care eliminates the need for providers to submit claim data or attachments requiring editing. This business process queries national and regional registries for member and provider information, thereby obtaining more definitive and extensive source data, especially relating to member third party resources because all known payers will be listed in the members' records. The Edit process, using repository meta-data in the registry records, is also able to locate and query the members' Clinical data to validate health status data in order to ensure the appropriate coding of services and reduce the need for suspending claims/ encounters for additional information. The Edit process can rely on the real time updates to the	Through peer-to-peer collaboration, member and provider data accessible in regional registries are recognized by all participating applications as the "source of truth" – eliminating the necessity for the provider to send this information and for the Edit process to validate against its version of the information; the CLINICAL DATA assists the provider with coding and data required by Medicaid and other payers' payment rules, alerts the provider about clinical prerequisites for service coverage, such as diagnoses, functional or health status, or clinical test results. Preconditions for this achieving this level are use of established RHIOs and semantic interoperability.
Encounter data is received via tape in state-specified format and data content.	Encounter data is received electronically or is posted to Web sites and uses state specified, non-HIPAA-compliant formats.	Encounters are submitted as HIPAA compliant COB claims from managed care organizations and any other external processor, e.g., a PBM, mental health, dental processor, or other agency. Encounter data meets MITA standard interface requirements.		
Sister agencies and waiver programs manage their own Edit and Audit Claim process.	Medicaid agency can accept sister agency and waiver program claims and load other agency data into an enterprise data warehouse by supporting multiple	Medicaid agency coordinates with other sister agencies and waiver programs to accept, process, and access MITA standard data elements.		

OM2 Edit and Audit Claim/Encounter: Business Capabilities[1]

Edit and Audit Claim/Encounter				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	formats and mapping non-standard data elements.		Reference Repository from authoritative sources for definitive coding schemes. In addition, the Edit process can locate members' primary payers' benefit repository, using pointers in the members' records, to access services covered under each third party resource, thereby validating service coverage to conduct COB more efficiently.	
Business Capability Qualities: Timeliness of Process				
Suspended claims require lengthy manual resolution.	Electronic claim processing and POS adjudication greatly increase timeliness.	(TBD)	(TBD)	(TBD)
Data Access and Accuracy				
As a result, data are not comparable across silos. For EDI claims/encounters, edits are automated for many steps, but are manual for attachments and suspended claims/encounters Claims/encounter EDI format and content is not HIPAA compliant. Attachment data is unstructured; it is difficult for reviewers to consistently interpret and apply adjudication rules.	However, waiver claims continue to be submitted to siloed payment systems using state specific format and data, such as provider type and service codes. As a result, data continues to lack comparability across silos.	All programs, even those not covered under HIPAA, use semantically interoperable data in the edit process.	Real-time access to source data ensures accuracy and improves process performance. This also enables enhanced business activity monitoring is based on optimal data streams to fine-tune business process rules to meet operational parameters, thereby ensuring that Agency objectives are met.	Access to additional data from national sources adds to accuracy of editing.

OM2 Edit and Audit Claim/Encounter: Business Capabilities[1]

Edit and Audit Claim/Encounter				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Effort to Perform; Efficiency				
For EDI claims/encounters, edits are automated for many steps, but are manual for attachments and suspended claims/encounters Inflexibility in Edit processing is a key factor in the proliferation of siloed payment systems outside of the MMIS, especially for waiver programs that determine member eligibility, enroll providers and pay for services differently than traditional Medicaid programs. COB is conducted by denying claims using the resource intensive payer-to-provider model. Edited fields are validated against standard and state-specific code sets.	If a claim/encounter data set fails edit validation, the process can now generate an electronic request for corrections via an X12 276. If additional information is required, an electronic request is made, e.g., via an X12 277.	Standardized data and edit rules enable tracking of overutilization of similar services that are coded differently for disallowance. As a result, all siloed payment systems are integrated or retired, saving resources and optimizing FFP; and data quality is improved. Edit processing is highly flexible so that edit rules and code set changes can be made quickly and inexpensively. Edit rules engines support complex algorithms so that benefit packages can be customized for members eligible for multiple programs. Edits can be structured for both traditional and waiver programs.	Claim processing is replaced by direct communication between provider system and payer system.	
Cost-Effectiveness				
Maintenance is expensive and time-consuming. Rules lack flexibility and are costly to change. Therefore, when new programs, code sets, or edits are added, claims/encounters with these	Maintenance continues to be expensive and time-consuming.	All claims for members with known third party resources are flagged for payer-to-payer COB, reducing provider burden and improving the timeliness of reimbursement.	See above	

OM2 Edit and Audit Claim/Encounter: Business Capabilities[1]

Edit and Audit Claim/Encounter				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
changes may need to be edited manually, which may not be cost effective in the long term.				
Accuracy of Process Results				
Results meet agency requirements for timeliness and accuracy.	Despite progress, related processes continue to be tightly integrated, so that changes to edits can result in unintended downstream processing consequences.	Related processes are de-coupled, allowing changes to be made in the Edit Claim/ Encounter process with reduced potential for unintended downstream processing consequences. The Edit Claim/Encounter process is completely automated and only rare edit exceptions must be manually reviewed. Optimizing automation improves error rates and timeliness, thereby enabling support of real-time claims/encounter processing.	See above	
Utility or Value to Stakeholders				
Stakeholders: the provider, the member, the care manager, agency staff; other agency; other payer; government; the public.	This increases the number of small providers who can submit electronically.	Agency staff are free to focus on strategic perspectives because operations are automated and accurate.	(TBD)	

OM2 Edit and Audit Claim/Encounter: Business Capabilities[1]

Edit and Audit Claim/Encounter				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: Even at Level 1 there is significant automation in the Edit & Audit process. At Level 2, the agency accepts HIPAA data but converts to internal codes. At Level 3, the MITA standard interface subsumes the HIPAA standard data and uses it in the Edit & Audit process. At Levels 4 and 5 there is a paradigm shift to a new business process that replaces “Edit and Audit Claim/Encounter” with direct messaging between the provider’s clinical record and the payer system.

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OM2 Price Claim/Value Encounter: Business Capabilities[1]

Price Claim/Value Encounter				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Standard Medicaid services are automatically priced using rate and fee reference data. Values are assigned to services reported on encounters, using the same reference data. "By-report" pricing is performed manually. This manual process is often used to accommodate changes in policy and pricing. Staff manually prepare adjustment transactions including application of member contributions, provider advances, deduction of liens and recoupments. Waiver program and a-typical provider services are manually priced.	More services are automatically priced and there are fewer "by-report" manual pricing exceptions. Most single claim adjustments are automated. State Medicaid agency can support payment of waiver program and a-typical providers. Pricing formulas are agency-specific.	Medicaid agency coordinates with sister agencies and waiver programs to present a one-stop shop claim adjudication and pricing process. The agency uses MITA standard interfaces to price claims and value encounters. Flexible business rules allow maximum flexibility in changing pricing algorithms.	Pricing is embedded in the provider to payer system communication. As the provider enters service data into the clinical record, authorization and pricing are immediately established by the payer application. Adjustment process (TBD).	The agency uses the NHIN to compare and select prices based on regional averages or other new pricing methodologies (TBD). Supports regional pricing profiles that can be factored into the pricing methodology, e.g., a new pricing rule: "Pay the amount billed or the regional average (Region = ME, NH, VT), whichever is lower"… or, "Pay the regional per diem no matter what is billed".
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				

OM2 Price Claim/Value Encounter: Business Capabilities[1]

Price Claim/Value Encounter				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Accuracy of Process Results				
Utility or Value to Stakeholders				
Stakeholders: the provider, the member, the care manager, agency staff; other agency; other payer; government; the public.				
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: Level 2 pricing is widely automated using agency-specific business rules. Level 3 provides one-stop shop pricing service for Medicaid and cooperating agencies, using MITA national standards for pricing and valuation. Level 4 leapfrogs over the traditional claims processing and establishes a provider system to payer system direct dialogue that includes pricing. Level 5 expands capabilities to include data exchange with other states to inquire about pricing policies.

OM2 Apply Claim Attachment: Business Capabilities[1]

Apply Claim Attachment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Paper claim attachments are sent separately from the claim; the two documents are matched up, requiring some manual intervention. There are limited, agency-specific requirements for the attachments. Medical records are delivered in paper format with no standards.	The agency receives a mix of paper and electronic attachments. Electronic attachments are automatically matched to corresponding claim. Electronic attachments meet HIPAA standards with agency-specific Implementation Guide instructions. Some manual processing is still required.	Electronic attachments are required for electronically submitted claims. Electronic attachments meet MITA standard interface requirements. Agency continues to accept paper attachments from a small number of disadvantaged providers who still submit paper claims.	Attachments are no longer required because the payer has direct access to the clinical data stored in the clinical data record.	Through the NHIN, the Medicaid agency can view clinical data stored in Clinical data in any location in the country. Attachments are no longer needed.
Business Capability Qualities: Timeliness of Process (TBD)				
Claims requiring attachments are subject to delays.	Electronic attachments shorten time required to match with claim and edit.	Use of MITA national standards for claims attachments increases speed of processing.	Clinical information needed for adjudicating payment for a service is instantly accessed.	Clinical information needed from any source outside the agency/state is available instantly, nationally.
Data Access and Accuracy				
Manual matches and reviews result in inconsistency and errors.	Electronic attachments increase accuracy. State complies with HIPAA standards but also has its own IG requirements.	Electronic attachments are required for electronic claims and a MITA national standard is used. This increases access and accuracy of data.	Access is immediate. Accuracy increases based on direct access to source clinical data, no translation.	Same as Level 4, with data available nationally.
Effort to Perform; Efficiency				
Labor-intensive; requires professional review staff.	Electronic attachments reduce staff requirements. More managed care enrollment means fewer claims/attachments.	Use of MITA national standards for the Claim Attachment facilitates performance.	No human intervention is required, therefore, high level of efficiency.	No human intervention is required on a national scale, therefore, maximum efficiency.

OM2 Apply Claim Attachment: Business Capabilities[1]

Apply Claim Attachment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Cost-Effectiveness				
Costly, but meets agency goals for ensuring appropriateness of payment.				
Accuracy of Process Results				
There are inconsistencies in results in the manual matching and processing of attachments.	Accuracy is improved.	Accuracy is improved.	High-level of accuracy.	Maximum accuracy.
Utility or Value to Stakeholders				
			Providers and payers share in the benefit of immediate access to clinical information needed to adjudicate a claim.	The benefit increases with access to clinical data nationally.
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: At Level 2 there is a mix of paper and electronic claims attachments. Electronic attachments are HIPAA-compliant. At Level 3, electronic claim submitters must submit electronic claim attachments that meet MITA national standards. At Level 4, attachments are eliminated because the payer has direct access to clinical information. The Level 4 access to clinical data is extended to a national basis.

OM2 Apply Mass Adjustment: Business Capabilities[1]

Apply Mass Adjustment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The agency identifies the claims to be adjusted, sets the parameters, and applies the retroactive rates through primarily manual processes.	Improvements throughout the Medicaid program operations reduce the number of mass adjustments required. Identification of claims to be adjusted and application of the adjustment are automated with audit trail. Adjustment data is specific to the agency.	MITA standard interfaces for mass adjustments are used by the state Medicaid agency. The process has the flexibility to easily change the criteria for identification of claims and application of the adjustment. Other agencies that might be affected by the mass adjustment collaborate with the Medicaid agency.	(TBD)	(TBD)
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM2 Apply Mass Adjustment: Business Capabilities[1]

Apply Mass Adjustment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: Level 2 improves automation; data standards are specific to the agency. Level 3 uses MITA national standards for the business rules used to identify claims and the application of the mass adjustment.

OM3 Prepare Remittance Advice/Encounter Report: Business Capabilities[1]

Prepare Remittance Advice/Encounter Report Capability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Medicaid agency produces the paper Remittance Advice using state Medicaid agency-specific format and data content. The RA itemizes the services that are covered in the payment and explains which services are not being paid or are being changed and the reason why. Explanations of codes are comprehensive and agency-specific.	Medicaid agency continues to provide paper RAs to providers who are not electronic billers. The agency complies with HIPAA to supply an electronic RA that meets state agency Implementation Guide requirements.	The agency uses MITA standard interfaces for the RA. Paper RAs are still supported on an exception basis. All electronic billers receive ERAs. Through inter-agency coordination, multiple agencies can use the same ERA data standard.	With provider clinical system to payer system communication, the RA is replaced by a new accounting mechanism, (TBD).	Payment information can be sent to any location in the country via the NHIN.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM3 Prepare Remittance Advice/Encounter Report: Business Capabilities[1]

Prepare Remittance Advice/Encounter Report Capability				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: Paper Remittance Advices continue at higher levels only to accommodate small numbers of providers. Level 2 encourages ERAs and aligns with HIPAA standards as interpreted by the Medicaid agency. Level 3 implements MITA national standards for EFT which are also available to sister agencies within the state. Level 4 introduces communication directly between the provider clinical records and the payer payment systems and the ERA is replaced by reporting (TBD). Level 5 supports sending remittance information anywhere in the U.S.

OM3 Prepare Coordination of Benefits: Business Capabilities

Prepare Coordination of Benefits				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Medicaid agency identifies claims subject to COB prior to payment (Cost Avoidance) based on defined criteria. The claim subject to COB is denied and returned to the provider indicating requirement to bill the primary payer first. Post payment recovery (Pay and Chase) claims are sent to third party payers using a mix of paper and EDI claims with non-standard data resulting in inconsistent application of rules, delays, and labor intensive efforts. It is difficult to adapt to new policies for COB. COB processes are closely integrated with claims adjudication, pricing, and remittance advice, so changes affect all the interrelated processes. Maintenance is expensive and time-consuming.	Medicaid agency continues to use the resource intensive payer-to-provider model for Cost Avoidance requiring providers to submit denied claims to other payers. Some cost avoided claims are forwarded to primary payers. A mix of automated and manual processes is used to identify post payment recovery (Pay and Chase) claims which are submitted to third party payers using a mix of paper and non-standard EDI claims. Maintenance of COB processes continues to be labor intensive. COB processes are tightly integrated, resulting in expensive and time-consuming efforts to implement changes.	The agency uses MITA standard interfaces for claim adjudication and COB. The ***Prepare COB*** process is completely automated and only in rare exceptions requires manual intervention. Cost avoided claims are immediately forwarded to primary payers. Some claims are flagged manually for forwarding to a third party on an exception basis. Post payment recovery (Pay and Chase) claims are submitted to third party payers using MITA national standards. Flagging of post payment recovery claims is completely automated and only requires manual identification of recovery claims under limited circumstances. Optimizing automation improves error rates and timeliness of this process. Post payment recovery processing is highly flexible and supports complex algorithms so that rules and code set changes can be	The previous COB process is replaced by payer to payer communications. The agency queries regional registries for pointers to repositories of member's third party resources. Meta-data is used to locate the records and to ensure data interoperability. Real-time access to source data ensures accuracy and improves process performance.	The agency can query registries across the country for pointers to repositories of member's third party resources.

OM3 Prepare Coordination of Benefits: Business Capabilities

Prepare Coordination of Benefits				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
		made quickly and inexpensively. Related processes are de-coupled, allowing changes to be made in the ***Prepare COB*** process with reduced impact on related business processes. All COB is coordinated among data sharing partner agencies in the state.		
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

OM3 Prepare Home and Community-Based Services (HCBS) Payment: Business Capabilities[1]

Prepare HCBS Payment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The ***Prepare Home & Community Based Services Payment*** business process is primarily paper/phone/fax based processing with limited EDI. HCBS programs are separated and uncoordinated. There is no standardized data. Payments are non-standard and cover a variety of a-typical providers. Some payments are salary-based.	The Medicaid agency works with HCBS programs to share Medicaid processes. Some HCBS programs use Medicaid business processes for service authorization and service payment. HCBS providers agree to use Medicaid standards for prior authorization and claims adjudication and payment.	Medicaid agencies and sister agencies agree to use MITA standard interfaces for payment transactions.	HCBS programs benefit from payer system to provider system communications for immediate approval of payment. Payment authorization is embedded in the provider to payer system communication. As the provider enters service data into the clinical data record, authorization is immediately established by the payer application.	Payments can be made anywhere in the U.S. Other capabilities: (TBD)
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM3 Prepare Home and Community-Based Services (HCBS) Payment: Business Capabilities[1]

Prepare HCBS Payment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: At Level 2, HCBS programs use Medicaid payment processes. Level 3 implements MITA standard interfaces for payments and HCBS accept these standards. Level 4 benefits from access to provider clinical information to automate payment. Level 5 supports communications between one state agency and any other agency anywhere in the U.S.

OM3 Prepare Explanation of Benefits: Business Capabilities[1]

Prepare EOB				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Medicaid agency complies with federal regulations to produce random samples of EOMBs quarterly and mail to members. Members are asked to read the EOMB and report on any discrepancies. Sensitive services are suppressed.	Medicaid agency enhances the sampling process to target selected populations. Member responses are automatically tabulated. Cultural and linguistic adaptations are introduced.	The agency uses MITA standard interfaces for the EOMB. Other agencies collaborate with Medicaid in the EOMB process.	EOMB is replaced by a Personal Health Record. The agency has access to clinical data and can directly analyze services recorded and reported. The agency can communicate with individuals who appear to need special attention.	Personal Health Records are accessible anywhere in the U.S. via the NHIN.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM3 Prepare Explanation of Benefits: Business Capabilities[1]

Prepare EOB				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

1 Summary of Levels 2-5: Level 2 adds automated flexibility in creating EOMB targets and adds cultural and linguistic adaptations. Level 3 implements MITA national standards for EOMB messages. Level 4 provides the member with direct access to a Personal Health Record. Level 5 supports member access to Personal Health Records anywhere in the U.S.

OM3 Prepare Provider EFT/Check and Prepare Premium/Capitation EFT/Check: Business Capabilities[1]

Prepare Provider EFT/Check And Prepare Premium/Capitation EFT/Check				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Medicaid agency or Department of Finance produces the EFT transaction or a paper check using Medicaid agency or state DOF standards for format and data content.	Medicaid agency complies with state or industry standards for EFT transactions and conforms with HIPAA where appropriate. Agency encourages electronic billers to adopt EFT payment.	The agency uses MITA standard interfaces for EFT transactions. Paper checks are produced where required for exceptional circumstances. All electronic billers receive EFT payment. Through inter-agency coordination, multiple agencies share the same EFT process.	Payments are made directly to provider bank accounts triggered by entries into clinical records maintained by the provider and accessed by the payer. Premium payments are made directly to MCO, insurance company, Medicare buy-in, et al bank accounts based on enrollment information.	EFT payments are distributed to any location in the country via the NHIN.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM3 Prepare Provider EFT/Check and Prepare Premium/Capitation EFT/Check: Business Capabilities[1]

Prepare Provider EFT/Check And Prepare Premium/Capitation EFT/Check				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: This Business Capability matrix covers two Business Processes – Prepare Provider EFT/Check and Prepare Premium/Capitation EFT/Check. Paper checks continue at higher levels only to accommodate small numbers of providers including a-typical. Level 2 encourages EFT and aligns with HIPAA standards as interpreted by the Medicaid agency. Level 3 implements MITA national standards for EFT which are also adopted by sister agencies within the state. Level 4 introduces communication directly between the provider clinical records and the payor payment systems. Level 5 supports EFT payments from one agency to any other agency anywhere in the U.S.

OM4 Prepare Health Insurance Premium: Business Capabilities[1]

Prepare Health Insurance Premium				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The agency identifies members who meet criteria for buy-in to other insurance coverage through primarily manual processes including a cost/benefit analysis of the individual case. The agency enrolls the member and receives premium payment information. The agency pays the premium according to the insurance company requirements. At Level 1, these steps are mostly manual. There are no standards for these transactions.	The agency implements HIPAA-compliant standards for electronic premium payments, however, the other insurance companies impose their specific Implementation Guide requirements. Business rule to identify candidates and analyze cost/ effectiveness are automated on a state-specific basis. Some transactions continue to be manually processed at the request of the other insurer.	The agency uses MITA standard interfaces for identification of candidates for other payer buy-in, analysis of cost/ effectiveness, and health insurance premium payments. The agency has the flexibility to easily change the criteria for identification of members eligible for other insurance buy-in. Medicaid collaborates with other payers to use the national standards.	Payments are made directly to other insurer bank accounts via RHIO registries. Access to clinical information helps to identify members eligible for other insurance programs.	Agency can make premium payments to any insurer at any location in the country via the NHIN.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				

OM4 Prepare Health Insurance Premium: Business Capabilities[1]

Prepare Health Insurance Premium				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: Paper premium payments continue at higher levels only to accommodate small numbers of other insurers who may require paper. Level 2 encourages EFT and aligns with HIPAA standards as interpreted by the other insurer Implementation Guides. Level 3 implements MITA national standards for EFT which are also adopted by other insurers within the state. Level 4 introduces communication directly between the provider clinical records and the payer payment systems. Level 5 supports EFT payments from one agency to any other insurer anywhere in the U.S.

OM4 Prepare Medicare Premium Payment: Business Capabilities[1]

Prepare Medicare Premium Payment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The agency identifies members who meet criteria for buy-in to Medicare Part B. The agency exchanges information with the SSA using electronic communication standards specified by SSA. At Level 1, tape exchange is the primary medium. The agency prepares the Medicare Part B premium buy-in report.	CMS has not adopted the HIPAA standard for premium payment for this transaction so there is no national improvement available for this part of the process. Agencies use business rules to improve identification of buy-in candidates, prepare the premium payment calculation, and track the data exchange.	Medicaid agencies and CMS use a standard interface for the premium payment. The agency uses MITA standard interfaces for identification of candidates for Medicare Buy-in. The agency has the flexibility to easily change the criteria for identification of buy-in candidates. The agency collaborates with other agencies to identify potential buy-ins.	(TBD)	Agency can verify status of buy-in candidate in other states and jurisdictions via the NHIN before generating the premium payment.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM4 Prepare Medicare Premium Payment: Business Capabilities[1]

Prepare Medicare Premium Payment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: CMS does not support the HIPAA standard for premium payments at this time. Level 3 implements MITA national standards for premium payments. Level 4 is (TBD). Level 5 supports communications between one state agency to any other agency anywhere in the U.S.

OM4 Prepare Capitation Premium Payment: Business Capabilities[1]

Prepare Capitation Premium Payment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The agency identifies members who have elected or have been auto-assigned to a managed care organization, a benefit manager, or a primary care physician, and matches them to appropriate rate cells, to calculate monthly payments. Agency may use a modified claim adjudication process to support capitation payment preparation. Adjustments are manually applied. At Level 1, these steps are mostly manual. Standards for the capitation payment transaction are agency-specific.	The agency implements HIPAA-compliant standards for electronic premium payments, however, the other insurance companies impose their specific Implementation Guide requirements. Business rules used to identify candidates are automated on a state-specific basis. Some transactions continue to be manually processed at the request of the other insurer.	The agency uses MITA standard interfaces which incorporate HIPAA premium payment schema for identification of managed care program enrollees, and preparation of the capitation premium payments. The agency has the flexibility to easily change the criteria for rate cells.	Payments are made directly to managed care bank accounts via RHIO registries. Clinical information is accessed directly from the MCO/PCP if the capitation payment is supplemented for special circumstances, e.g., high risk pregnancy.	Agency can make premium payments to any managed care organization or insuring organization at any location in the country via the NHIN.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				

OM4 Prepare Capitation Premium Payment: Business Capabilities[1]

Prepare Capitation Premium Payment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

[1] Summary of Levels 2-5: At Level 1 the agency uses the claims payment process to produce capitation payments. At Level 2, capitation payments are automatically produced and conform to HIPAA standards. At Level 3, the agency uses MITA standard interfaces. At Level 4, RHIOs orchestrate transfer of funds to MCO accounts and access clinical information to determine special payments. At Level 5, premium payments can be sent to any U.S. location.

OM5 Manage Payment Information: Business Capabilities[1]

Manage Payment Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the Manage Payment History business process is focused primarily on meeting traditional FFS program needs as reflected in MMIS certification requirements such as SURS and MARS reporting. The process is rigidly tied to legacy technology making it difficult to use the process for broader purposes. Data is largely non-standardized and vary by siloed programs. Encounter and waiver program payment data are likely stored in different systems. The source of the data is a mix of manual updates, data entry, OCR and proprietary EDI. As a result, output data used for reporting lacks comparability. Payment data is not timely because batch updates are scheduled around legacy system production cycles, OCR and data entry of paper claims, and the manual nature of claim resolution within the adjudication process.	At this level, the Manage Payment History business process is more responsive to meeting the needs of managed care and waiver programs. Data sources are primarily electronic interchange such as EDI, POS and Web portals, and now include electronic encounter, managed care and Medicare premium, COB, TPL, waiver program and member payment data. Agencies begin centralizing and coordinating payment processes and standardizing internal payment history data. Data sources are increasingly HIPAA 837 claims. However, encounter and waiver program payment history data continues to be proprietary. Although the internal data must be mapped to these different data sources, the ability to compare data across programs has improved, broadening the usefulness of payment history, e.g.,	At this level, the Manage Payment History business process is now an enterprise resource that provides real time access to quality, complete and semantically interoperable data via record locator services that federate all programs' payment history. The use of non-electronic interchange and non-standard payment data is eliminated. All programs use HIPAA 837 data for claims history records, including COB and encounter data. Claims attachments are compliant with the X12 275. Premium payment data is compliant with the HIPAA 834. All payment history data, including that not required to meet HIPAA, such as member payments, are stored internally accordance with a standards-based UML data model that vastly improves comparability across programs. Claims may be processed in	At this level, the Manage Payment History business process interfaces with external business processes via regional record locator services. Due to the real time adjudication of claims, claims data is available almost immediately. Profiles of Medicaid enterprise payment history by member, provider, service or condition are accessible to authorized external users to inform clinical encounters, quality reporting, fraud and abuse detection (ability to compare Clinical data with claims data in real time), and public health surveillance (detecting patterns of reportable conditions and potential incidents). Record locator services may be provided by semantic Web search engines. Emerging use of online publish and subscribe capabilities or other information content management capabilities enable push and pull of data	At this level, the Manage Payment History business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing. Claims are no longer sent or compiled by the Agency, and instead, users of claims history data locate and compile clinical episode of care data within EHRs via record locator services or search engines on a real time, as need basis. In addition, applications pull and consume data available via URIs provided by semantic Web search engines, and there is systemic use of online publish and subscribe capabilities to automatically feed new data to authorized applications based on business rules.

OM5 Manage Payment Information: Business Capabilities[1]

Manage Payment Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Data availability is limited by siloed systems' reporting capabilities. Using payment data for profiling members, providers, program analysis, or outcome measures requires costly and untimely statistical manipulation.	program and provider performance monitoring. Adjudication process automation improves timeliness of compiling payment history. However, with the exception of Pharmacy POS, payment history updates continues to be scheduled around legacy systems' production cycles. Rudimentary decision support, reporting and analysis tools, and data mart capabilities improve users' ability to reliably and cost effectively access the payment history they require for purposes beyond compliance with MMIS certification requirements.	real time; and automation of most adjudication and premium processes, including the processing of structured data within claims attachment markedly improves the availability, quality, completeness and timeliness of payment data. Decision support and sophisticated analytic tools enable users to compile member, provider, service or condition specific profiles and perform complex ad hoc analysis and reporting in real time.	to EHRs, PHRs and public health, e.g., BioSense based on receivers' criteria.	
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				

OM5 Manage Payment Information: Business Capabilities[1]

Manage Payment Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

[1] The Operations Management Business Area services the members and providers with Service Review, Payment Management, Payment Information, Member Payment Management, and Cost Recoveries. The Business Objectives for this Business Area are: Match appropriate services to member health and functional needs with service referrals, authorizations and treatment plans; improve timeliness and accuracy of claims and capitation payment, remittance advice, member payment invoicing, spend-down calculation, cost recoveries, TPL, drug rebate, provider recoupment, and settlements; and improve accessibility, quality and timeliness of payment data, including encounter data.

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OM5 Inquire Payment Status: Business Capabilities[1]

Inquire Payment Status				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The claim status inquiry process is primarily a manual process and is associated with a specific service. Providers inquire about the current adjudication status of a claim by phone, fax, or paper. Staff performs search on the claims history data store (for claims in process) or the claims history repository for claims that have been adjudicated. Search may be based on the claim ICN, date of service, or patient name. Staff locates the data and relay it to the provider by phone, fax or paper. Process is time-consuming for providers and resource intensive for agency.	Programs employ AVR, legacy direct data entry, and point of service devices for electronic claim status responses. Staff may still manually handle inquiries that are not resolved with automated response. The data uses agency standards and access is less time-consuming, less burdensome, and requires fewer agency resources.	All programs use a centralized automated electronic claim status process. Interfaces use MITA standards. Providers send HIPAA X12 276 or use online direct data entry and receive HIPAA X12 277 response or find the claim status online. Data is standardized; access is 24x7, and is completely automated for the provider.	At Level 4, claims processing is replaced by direct communication between the provider's CLINICAL DATA system and the payer system. Adjudication results are known immediately, eliminating the need for claim status inquiries. Provider systems collaborate with the MMIS during an episode of care. The providers' systems alert the provider to any clinical protocols and to any business rules required by the agency in order for the service to be paid. When the episode of care has concluded, the service is reimbursed or not and the provider knows the payment status immediately, eliminating the need for payment status inquiry.	At Level 5, inquiries can be launched and responded to nationally through the NHIN.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				

OM5 Inquire Payment Status: Business Capabilities[1]

Inquire Payment Status				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

[1] Optional.

OM6 Calculate Spend-Down Amount: Business Capabilities[1]

Calculate Spend-Down Amount				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The Calculate Spend-Down Amount business process is primarily paper based. An applicant's costs for health services are tracked by adding paper bills and receipts until the spend-down amount for each period is met. Applicants may be required to submit a paper spend-down report. Staff applies spend down rules to decide whether the submitted costs are allowable and in which period to apply the costs, sometimes resulting in inconsistent determinations or controversy with the applicant. If spend-down is met, staff keys change in eligibility status into the applicant's record so that subsequent claims will pay for a specified period.	The Calculate Spend-Down Amount business process is conducted electronically. Applicants submit electronic spend-down reports, and either scan, fax, or mail health care bills and receipts. If spend-down is met, staff keys change in eligibility status into the applicant's record so that subsequent claims will pay for a specified period. Although the X12 270-271 supports transmission of spend down information, this purpose is not mandated by HIPAA. Providers have difficulty determining whether the member has a spend down requirement and how much the member must still pay before the provider may bill Medicaid. As a result, providers unnecessarily submit claims that are denied because the member has not yet met spent down requirements and there is no member accounting accumulator for	The Calculate Spend-down Amount business process does not require that members report their costs. Instead, members are made eligible for Medicaid coverage with a deductible amount equal to their spend-down requirements for the specified period. Agencies support transmission of spend down information on the X12 270-271. Providers are able to determine the spend-down amount when they verify eligibility. Providers submit claims which are denied for billing to the member until spend down is met. The member's account accumulator automatically accounts for excess resources during claims processing by debiting the amount paid by the member. Once spend-down has been met, Medicaid payments to begin and/or resume. Spend down is essentially eliminated as a distinct	Providers enter new service information into clinical records at various locations. If a client is flagged as a candidate.	N/A

OM6 Calculate Spend-Down Amount: Business Capabilities[1]

Calculate Spend-Down Amount				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	member payments toward meeting spend-down.	business process. From the perspective of providers and members, other than billing the member, there is no difference between spend down and the processing of other Medicaid claims.		
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

[1] At Level 1, the Calculate Spend-down business process is almost entirely manual. At Level 2 electronic reporting is added to capture out of pocket expenditures.

OM6 Prepare Member Premium Invoice: Business Capabilities[1]

Prepare Member Premium Invoice Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The agency uses manual procedures to maintain member accounting for premium invoicing and payment; maintain transaction history of all monies received or paid out of the member account; and reimburse members for HIP payments; and support member contribution accumulators to determine out of pocket maximums or spend down requirements. Member liability records are siloed by program and based on program specific eligibility records. Invoicing and payment receipt are manual processes requiring data entry for payment processing and for the changes in member liability due to eligibility status. Member accounting may be program specific, resulting in members receiving invoices and reimbursements from, and making premium payments to different parts of the Agency.	Program specific accounting modules maintain a detailed transaction history of all monies received from members, such as pay-in or premiums, and monies paid out from a member's account to reimburse for HIPP payments. Member account records are created when staff input amounts received from member pay-in or premium payment collection. Current balances and transaction history are stored for online viewing. Payments are subject to program specific rules. Notices are automatically generated by each program and sent on paper to members advising them of their hearing rights and the amount of their contribution.	Information from all program eligibility systems is used to establish the amount of the member liability in a centralized member accounting system associated with the Member Registry. Member liability amounts are updated by MMIS with online adjustment capability. The process creates a debit when payments are made; overpayments are credited to the account and refunds made to the member by check, EBT. Notices automatically are sent to the member from a central enterprise-wide member communications management business area advising them of their hearing rights and the amount of their client contribution. Notices are automatically sent to the member when annual maximums are met for any program. Member cost sharing accounts are maintained and updated by claims or	(TBD) [Could include tracking of member premium payments through PHR.]	

OM6 Prepare Member Premium Invoice: Business Capabilities[1]

Prepare Member Premium Invoice Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Total payments are manually compared to the member's benefit package requirement for out of pocket expenses. Notices are manually generated and sent on paper to members advising them of their hearing rights and the amount of their contribution.		member direct premium or pay in payments activity. Total payments are automatically compared to the member's benefit package requirement for out of pocket expenses. Payments can be accepted at all Agency sites. Payment can be in the form of cash, check, or credit or debt card. Details of the transaction are posted to the member accounting modules on the MMIS and then sent to the Agency financial systems.		
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM6 Prepare Member Premium Invoice: Business Capabilities[1]

Prepare Member Premium Invoice Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

[1] Member Accounting includes member cost-sharing through the collection of premiums for medical coverage and co-payments that accumulate until an out of pocket maximum is met. Also includes reimbursement to the Member for premiums paid under HIPP.

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OM7 Manage Recoupment: Business Capabilities

Manage Recoupment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Manage Recoupments*** process is likely primarily a manual process. Communications to providers and other payers are accomplished via phone and mail. Format is not HIPAA compliant, recouping of monies in third party liability situations is accomplished from payer to provider rather than payer to payer. Non-standardized data makes any type of cross program performance monitoring, management reporting, fraud detection, or reporting and analysis difficult and costly. Maintenance continues to be expensive and time-consuming.	At this level, the ***Manage Recoupments*** process is increasing its use of electronic interchange and automated processes. Some agencies are sending electronic 837s directly to other payers rather than from payer to provider. There is an increase in coordination between the provider utilization role, recoupments and accounting resulting in rule application consistency. More of the formatting is HIPAA compliant resulting in standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.	At this level, the ***Manage Recoupments*** business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. There is more application-to-application communications e.g., applying refund in the system and updating payment history which results in less manual intervention resulting in less maintenance and time savings. Data is standardized for automated electronic interchanges and interoperability. Communications to providers are consistent, timely and appropriate.	At this level, the ***Manage Recoupments*** business process interfaces with other processes via federated architectures, e.g., from Medicaid agency to an outside entity or payer.	At this level, ***Manage Recoupments*** business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				

OM7 Manage Recoupment: Business Capabilities

Manage Recoupment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

OM7 Manage Estate Recovery: Business Capabilities

Manage Estate Recovery Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level the ***Manage Estate Recovery*** business process is primarily a mix of paper, phone, fax and proprietary EDI. Non-standardized data and format from multiple sources requires manual compilation of data. Access to data is limited by the sporadic, inconsistent, and untimely receipt of data and updates to member eligibility. Generating correspondence, e.g., demand of notice to probate court to member's personal representatives and notices of intent to file claim, is not timely. Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing. This adversely affects the accuracy and amount of recovery which could in turn affect many stakeholders.	At this level, the ***Manage Estate Recovery*** business process uses electronic interchange and automated processes, for example, receiving data from Community Service Offices, date of death matches, probate petition notices and reports of death from nursing homes which increases coordination and improves timeliness, consistency, and access for stakeholders involved in the process. Agencies are standardizing data to increase coordination and consistency, therefore enhancing usefulness for determining the value of estate liens and improving the timeliness and accuracy of the case follow-up, ensuring recovery is completed and Member registry and payment history are updated.	At this level, the ***Manage Estate Recovery*** business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. MITA standard interfaces are used for electronic interchanges (interfaces) between agencies. Communications to stakeholders and member's personal representatives are consistent, timely, and appropriate.	The data exchange necessary for estate recovery is accessed via regional registries for member and third party resources.	Data exchange is on a national scale. Through peer-to-peer collaboration between the agency and provider EHRs or other program applications, e.g., health departments for date of death matches, real-time access to source data ensures accuracy, eliminates redundant collection and interchange of data and improves process performance.
Business Capability Qualities: Timeliness of Process (TBD)				

OM7 Manage Estate Recovery: Business Capabilities

Manage Estate Recovery Business Process				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

OM7 Manage TPL Recovery: Business Capabilities

Manage TPL Recovery Business Processes				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
The ***Manage TPL Recoveries*** process is primarily a mix of paper, phone, fax and proprietary EDI. Information regarding third-party resources is manually validated. TPL recovery is accomplished primarily via payer-to-provider COB. Inconsistency in the rules applied to TPL recoveries vary from agency to agency. Programs are siloed so the recovery process may be uncoordinated. Non-standardized data and format makes any type of cross program management reporting, and analysis difficult and costly. Access to data is limited by inter-agency and other payer legacy systems, i.e., capability related to data matches. Reporting and responses from third party payers are not timely and data may not be accurate. Cost-effectiveness is impacted by lack of data accuracy and completeness,	The ***Manage TPL Recoveries*** process uses agency specified electronic interchange and automated processes. Electronic or magnetic tape downloads from other agencies are used for data matches support access to member eligibility data.	The ***Manage TPL Recoveries*** business process uses MITA standard interfaces for payer–to payer COB process reducing the burden to providers and optimizing timeliness. Data is standardized for automated electronic interchanges (interfaces) between agencies and other payers. Communications consistent, timely, and appropriate.	COB is automatically coordinated through the local RHIO registry. Response and payment outcomes are immediate. Regional stakeholders are interoperable and payment determinations or denials are entirely a payer-to-payer process making the data immediate, accurate and consistent.	Data exchange for COB occurs on a national scale. Through peer-to-peer collaboration, member and provider data is accessible through RHIO relays across the country. Real-time access to source data ensures accuracy, eliminates redundant collection and interchange of data, and improves process performance.

OM7 Manage TPL Recovery: Business Capabilities

Manage TPL Recovery Business Processes				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
as well as inconsistency in how the rules and/or policies are applied to TPL recoveries, manual processing and timeliness.				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

OM7 Manage Drug Rebate: Business Capabilities

Manage Drug Rebate				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Manage Drug Rebate*** business process is primarily paper invoice processing. Rebate information is manually validated. Programs are siloed so rebate process may be uncoordinated, e.g., mental health, waiver, and shared programs with health departments such as ADAP, pay for drugs but may not participate in the state drug rebate program. Non-standardized data and format makes any type of cross program management reporting and analysis for drug rebate purposes is difficult and costly. Access to data is limited by legacy systems and CMS reporting cycles. Reporting, analysis, and responses to pharmaceutical companies and CMS inquiries are not timely and data may not be accurate. Cost-effectiveness is impacted by lack of data accuracy and completeness (missing data from siloed	At this level, the ***Manage Drug Rebate*** business process uses electronic interchange and automated processes; for example, magnetic tape downloads and shared drives from legacy systems support state generation of rebate information. Agencies are centralizing drug utilization data from siloed programs as inputs to the drug rebate process to achieve economies of scale, increase coordination, improve rule application consistency, and standardize data to increase rebates.	At this level, the ***Manage Drug Rebate*** business process uses MITA standard interfaces. Data is standardized for automated electronic interchanges (interfaces) between agencies and drug manufacturers. The Agency supports data and technology integration and interoperability. Communications are more consistent, timely and appropriate.	Drug rebate is replaced by a new strategy where care management and disease management interact with provider EHRs.	Data exchange is on a national scale. Through peer-to-peer collaboration, real-time access to source data ensures accuracy, eliminates redundant collection and interchange of data, and improves process performance.

OM7 Manage Drug Rebate: Business Capabilities

Manage Drug Rebate				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
programs), manual processing, and need for CMS quarterly reporting of rebate information. These may factor into the Medicaid drug formulary and clinical protocol decisions, which affects many stakeholders.				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

OM7 Manage Settlement: Business Capabilities

Manage Settlement				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Manage Settlements*** business process is likely primarily paper based processing and some proprietary EDI. Non-standardized data makes any type of reporting and analysis difficult and costly. Programs create inconsistent rules across the Agency and Agencies apply their own rules inconsistently.	At this level, the ***Manage Settlements*** business process is increasing its use of electronic interchange and automated processes. Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting and analysis.	At this level, the ***Manage Settlements*** business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. Data is standardized for automated electronic interchanges (interfaces).	At this level, the ***Manage Settlements*** business process interfaces with other processes via federated architectures.	At this level, the ***Manage Settlements*** business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

OM7 Manage Settlement: Business Capabilities

Manage Settlement				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

Program Management

PG1 Designate Approved Service/Drug Formulary: Business Capabilities

Designate Approved Service/Drug Formulary				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Designate Approved Services/Drug Formulary*** process is primarily a manual process and may occur in silos without coordination i.e. different processes are used to make coverage determinations based on impacted systems, type of service and benefit package. Decisions are primarily based on fiscal impact and regulatory requirements rather than clinical data. Notification to trading partners is not timely and is labor intensive accomplished primarily on paper through use of provider mass mailings such as program memorandum. Communications to impacted members are not linguistically, culturally or competency appropriate and socio-economic barriers to accessing information and health care, such as those experienced by mobile communities are not addressed well.	At this level, the ***Designate Approved Services/Drug Formulary*** process begins to be coordinated across siloed systems and centralized by the enterprise. Review processes are centralized and standardized processes are emerging across systems, types of service and benefit packages. Decisions continue to be primarily based on fiscal impacts and regulatory requirements, but increased use of EDI increases accuracy of and access to clinical data to allow for limited analysis of health care outcomes as a determining factor. Agencies begin to centralize provider notification and client communication functions requiring fewer staff and capitalizing on efficiencies. Centralization increases consistency of communications; improves linguistic, cultural, and competency appropriateness; and lowers socio-economic	At this level, the ***Designate Approved Services/Drug Formulary*** process is highly automated. Increased use of EDI results in availability and accurate clinical data. Decisions are primarily based on clinical data and health care outcomes. Provider notification and client communications functions are centralized. Communications to customers are consistent, timely and appropriate. Customers are able to access the information required regardless of their entry point into the enterprise. The Agency actively supports and enables its customers to access information electronically.	At this level, a business process interfaces with other processes via federated architectures.	At this level, a business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.

PG1 Designate Approved Service/Drug Formulary: Business Capabilities

Designate Approved Service/Drug Formulary				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	barriers. Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.			
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

PG1 Manage Rate Setting: Business Capabilities (TBD)

Manage Rate Setting				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG1 Develop and Maintain Benefit Package: Business Capabilities

Develop and Maintain Benefit Package				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, benefit packages selections have pre-set services and provider types. Each eligible may be offered only packages available via eligibility determination pathway taken. Within each silo, eligible may only be assigned to the best available package available despite eligibility for more expansive services because systems may be limited to supporting one eligibility span at a time.	At this level, benefit package selections may still be limited for traditional Medicaid programs. However, Waiver programs may be structured to permit more flexibility around selection of services and providers within a benefit package.	At this level, all programs introduce flexibility within benefit packages, enabling "consumer driven" health care with more choices among services and provider types available within the funding limits of all benefit packages for which the member is eligible. Design of benefit packages is manual and is based on limited paper-based access to external clinical data.	At this level, services and providers are selected within funding limits of benefit packages available to the member based on clinical and socio-economic factors, as well as member preferences, such as health status, desire to remain in the home, what is culturally appropriate, and functional competencies. Design of benefit packages is automated with electronic access to electronic clinical data.	At this level, consumer-driven benefit packages are designed and updated real time based on collaborative interfaces with members' federated electronic health records. As clinical data indicates altering priority of services, the benefit package is optimally reconfigured for best health outcome within funding limits.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				

PG1 Develop and Maintain Benefit Package: Business Capabilities

Develop and Maintain Benefit Package				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Conformance Criteria for Each Level: (TBD)				

PG2 Develop and Maintain Program Policy: Business Capabilities (TBD)

Develop and Maintain Program Policy				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG2 Maintain State Plan: Business Capabilities (TBD)

Maintain State Plan				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG2 Develop Agency Goals and Initiatives: Business Capabilities (TBD)

Develop Agency Goals and Initiatives				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG3 Manage FFP for MMIS: Business Capabilities

Manage FFP for MMIS				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Manage Federal Financial Participation*** business process is likely primarily paper/phone/fax based processing and some proprietary EDI. Timeliness of responses to inquiries and data reporting is indeterminate.	At this level, the Manage Federal Financial Participation business process is increasing its use of electronic interchange and automated processes, e.g., OCR for paper transactions and AVR to automate phone lines. Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis. Centralization increases consistency of communications; improves linguistic, cultural, and competency appropriateness; and lowers socio-economic barriers. Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central	At this level, a business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. Agencies are run as enterprises with "cost centers" responsible for meeting performance benchmarks. Programs are agile and able to adjust their rules quickly when business activity monitoring indicates that the rules are no longer yielding desired benchmarks. Business areas are structured functionally and not by program/product line with infrastructure architected to support this design. Data is standardized for automated electronic interchanges (interfaces) that are oblivious to whether the sender or receiver is internal or external, applying appropriate levels of security to each requester / receiver. The Agency supports data and technology integration and interoperability.	At this level, a business process interfaces with other processes via federated architectures. ■ Incorporates Level 3 capability plus: – Virtual records – Use of clinical data – Focused data – data of record – Use of metadata – Self adjusting business rules – Use of clinical data to increase the accuracy of processes ■ Clinical staff focuses on exception cases. Members empowered to make own treatment decisions.	At this level, a business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing. ■ Improves on Level 4 capability plus: – Point-to-point collaboration – Content sensitive business logic – Business Process Management – Metadata – Shared nationally ■ Full interoperability with other local, state, and federal programs to provide complete virtual patient clinical record and administrative data ■ Access to national clinical guidelines Most services instantly authorized or denied from point of service; payment automatically established without need of invoice

PG3 Manage FFP for MMIS: Business Capabilities

Manage FFP for MMIS				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require. Improves on Level 1 capability plus by: ■ Point-to-point or wrapped connectivity to client ■ Point-to-point interfaces (trading partner agreements) segregated by interface type ■ Enhanced consistent timing for response to primary client ■ Different interfaces with different data format and semantics ■ Transactions are received and responded to via EDI, Web Portal Use of electronic Claim Attachment for Adjudication	Communications to customers are consistent, timely and appropriate. Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically. ■ Improves on Level 3 capability plus: – Virtual access to administrative and clinical records – Increased use of clinical data – Focused data – data of record – Use of metadata – Self adjusting business rules – Use of clinical data to increase the accuracy of processes ■ Clinical staff focuses on exception cases Members empowered to make own treatment decisions.		

PG3 Manage FFP for MMIS: Business Capabilities

Manage FFP for MMIS				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG3 Formulate Budget: Business Capabilities (TBD)

Formulate Budget				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG3 Manage State Funds: Business Capabilities

Manage State Funds				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, a business process is likely primarily paper/phone/fax based processing and some proprietary EDI. Programs are siloed so uncoordinated. Non-standardized data makes any type of cross program performance monitoring, management reporting, fraud detection, or reporting and analysis difficult and costly. Clinical data is rarely the basis for decisions, and requires accessing paper medical records. Most data is administrative use of encounter data. Timeliness of responses to inquiries and data reporting is indeterminate. Customers, including prospective and current members, providers, contractors, health plans, and other stakeholders have difficulty accessing consistent, quality, or complete information about programs, eligibility, services or providers.	At this level, a business process is increasing its use of electronic interchange and automated processes, e.g., OCR for paper transactions and AVR to automate phone lines. Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis. Centralization increases consistency of communications; improves linguistic, cultural, and competency appropriateness; and lowers socio-economic barriers. Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These	At this level, a business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. Agencies are run as enterprises with "cost centers" responsible for meeting performance benchmarks. Programs are agile and able to adjust their rules quickly when business activity monitoring indicates that the rules are no longer yielding desired benchmarks. Business areas are structured functionally and not by program/product line with infrastructure architected to support this design. Data is standardized for automated electronic interchanges (interfaces) that are oblivious to whether the sender or receiver is internal or external, applying appropriate levels of security to each requester/receiver. The Agency supports data and technology integration and interoperability.	At this level, a business process interfaces with other processes via federated architectures. ■ Incorporates Level 3 capability plus: – Virtual records – Use of clinical data – Focused data – data of record – Use of metadata – Self adjusting business rules – Use of clinical data to increase the accuracy of processes ■ Clinical staff focuses on exception cases Members empowered to make own treatment decisions.	At this level, a business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing. ■ Improves on Level 4 capability plus: – Point-to-point collaboration – Content sensitive business logic – Business Process Management – Metadata – Shared nationally ■ Full interoperability with other local, state, and federal programs to provide complete virtual patient clinical record and administrative data ■ Access to national clinical guidelines Most services instantly authorized or denied from point of service; payment automatically established without need of invoice.

PG3 Manage State Funds: Business Capabilities

Manage State Funds				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Communications are often not linguistically, culturally or competency appropriate and socio-economic barriers to accessing information and health care, such as those experienced by mobile communities are not addressed well. Programs create inconsistent rules across the Agency and apply their own rules inconsistently. ■ Indeterminate connectivity to client ■ Inconsistent timing for response to primary client ■ Multiple data formats and semantics ■ External inputs & outputs are received/sent manually via paper, telephone, & fax Transactions are individually reviewed using inconsistent interpretation of guidelines responded to via paper/USPD or fax.	changes improve customers' ability to reliably access the information and services they require. Improves on Level 1 capability plus by: ■ Point-to-point or wrapped connectivity to client ■ Point-to-point interfaces (trading partner agreements) segregated by interface type ■ Enhanced consistent timing for response to primary client ■ Different interfaces with different data format and semantics ■ Transactions are received and responded to via EDI, Web Portal Use of electronic Claim Attachment for Adjudication.	Communications to customers are consistent, timely and appropriate. Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically. ■ Improves on Level 3 capability plus: – Virtual access to administrative and clinical records – Increased use of clinical data – Focused data – data of record – Use of metadata – Self adjusting business rules – Use of clinical data to increase the accuracy of processes ■ Clinical staff focuses on exception cases Members empowered to make own treatment decisions.		

PG3 Manage State Funds: Business Capabilities

Manage State Funds				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG3 Manage F-MAP: Business Capabilities (TBD)

Manage F-MAP				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG4 Manage 1099s: Business Capabilities

Manage 1099s				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Manage 1099s*** business process is likely primarily paper/phone/fax based processing and some proprietary EDI. Programs are siloed and multiple 1099s may be created by different payment systems. Timeliness of responses to inquiries and data reporting is indeterminate.	At this level, the ***Manage 1099s*** business process is increasing its use of electronic interchange and automated processes. Agencies are centralizing common processes to achieve economies of scale and increase coordination. Centralization increases consistency of communications. Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party. These changes improve customers' ability to reliably access the information and services they require.	At this level, the ***Manage 1099s*** business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. Agencies are completely centralized. Data is standardized for automated electronic interchanges (interfaces). The Agency supports data and technology integration and interoperability. The Agency actively supports and enables its customers to access information electronically.	At this level, the ***Manage 1099s*** business process interfaces with other processes via federated architectures.	At this level, a business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				

PG4 Manage 1099s: Business Capabilities

Manage 1099s				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

PG4 Perform Accounting Functions: Business Capabilities (TBD)

Perform Accounting Functions				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG5 Develop and Manage Performance Measures and Reporting: Business Capabilities (TBD)

Develop and Manage Performance Measures and Reporting				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG5 Monitor Performance and Business Activity: Business Capabilities (TBD)

Monitor Performance and Business Activity				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG6 Manage Program Information: Business Capabilities (TBD)

Manage Program Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PG6 Maintain Benefit/Reference Information: Business Capabilities

Maintain Benefit/Reference Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, a business process is likely primarily paper/phone/fax based processing and some proprietary EDI. Programs are siloed so uncoordinated. Non-standardized data makes any type of cross program performance monitoring, management reporting, fraud detection, or reporting and analysis difficult and costly. Clinical data is rarely the basis for decisions, and requires accessing paper medical records. Most data is administrative use of encounter data. Timeliness of responses to inquiries and data reporting is indeterminate. Customers, including prospective and current members, providers, contractors, health plans, and other stakeholders have difficulty accessing consistent, quality, or complete information about programs, eligibility, services or providers.	At this level, a business process is increasing its use of electronic interchange and automated processes, e.g., OCR for paper transactions and AVR to automate phone lines. Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis. Centralization increases consistency of communications; improves linguistic, cultural, and competency appropriateness; and lowers socio-economic barriers. Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These	At this level, a business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. Agencies are run as enterprises with “cost centers” responsible for meeting performance benchmarks. Programs are agile and able to adjust their rules quickly when business activity monitoring indicates that the rules are no longer yielding desired benchmarks. Business areas are structured functionally and not by program/product line with infrastructure architected to support this design. Data is standardized for automated electronic interchanges (interfaces) that are oblivious to whether the sender or receiver is internal or external, applying appropriate levels of security to each requester/receiver. The Agency supports data and technology integration and interoperability.	At this level, a business process interfaces with other processes via federated architectures.	At this level, a business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.

PG6 Maintain Benefit/Reference Information: Business Capabilities

Maintain Benefit/Reference Information				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Communications are often not linguistically, culturally or competency appropriate and socio-economic barriers to accessing information and health care, such as those experienced by mobile communities are not addressed well. Programs create inconsistent rules across the Agency and apply their own rules inconsistently.	changes improve customers' ability to reliably access the information and services they require.	Communications to customers are consistent, timely and appropriate. Customers are able to access the information required regardless of their entry point into the enterprise, i.e., "No Wrong Door". The Agency actively supports and enables its customers to access information electronically.		
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

PG6 Generate Financial and Program Analysis/Report: Business Capabilities

Generate Financial and Program Analysis/Report				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
At this level, the ***Generate Financial & Program Analysis Reports*** business process is likely done with a mix of tape, CD and some proprietary EDI. Programs are siloed so uniformity of data is uncoordinated and non-standardized data makes any type of cross program performance monitoring, management reporting, fraud detection, or reporting and analysis difficult and costly.	At this level, the ***Generate Financial & Program Analysis Reports*** business process is increasing its use of electronic interchange and automated processes. Agencies are centralizing and standardizing data e.g., using taxonomy codes in lieu of provider type and specialty to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.	At this level, the ***Generate Financial & Program Analysis Reports*** business process has almost eliminated its use of non-electronic interchange and has automated most processes to the extent feasible. Agencies are run as enterprises with "cost centers" responsible for meeting performance benchmarks. Programs are agile and able to adjust their rules quickly when business activity monitoring indicates that the rules are no longer yielding desired benchmarks. Business areas are structured functionally and not by program/product line with infrastructure architected to support this design. Data is standardized for automated electronic interchanges (interfaces) Agency supports data and technology integration and interoperability.	At this level, the ***Generate Financial & Program Analysis Reports*** business process interfaces with other processes via federated architectures.	At this level, the ***Generate Financial & Program Analysis Reports*** business process collaborates with other processes in a peer2peer environment, eliminating redundant collection and interchange of data, and improving real-time, multi-axial processing.
Business Capability Qualities: Timeliness of Process (TBD)				

PG6 Generate Financial and Program Analysis/Report: Business Capabilities

Generate Financial and Program Analysis/Report				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

Business Relationship Management

Business Relationship Management: Business Capabilities (TBD)

Level 1	Level 2	Level 3	Level 4	Level 5
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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Program Integrity Management

PI Identify Candidate Case: Business Capabilities

Identify Candidate Case				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Mix of manual and automated processes.	Introduction of automated rules.	Standardized queries; automated alerts.	Direct access to clinical data.	Interoperability intra-state and interstate facilitates investigations.
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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PI Manage Case: Business Capabilities (TBD)

Manage Case				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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Care Management

CM Manage Medicaid Population Health: Business Capabilities (TBD)

Manage Medicaid Population Health				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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CM Establish Case: Business Capabilities (TBD)

Establish Case				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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CM Manage Case: Business Capabilities (TBD)

Manage Case				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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CM Manage Registry: Business Capabilities (TBD)

Manage Registry				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Capability Descriptions				
Business Capability Qualities: Timeliness of Process (TBD)				
Data Access and Accuracy				
Effort to Perform; Efficiency				
Cost-Effectiveness				
Accuracy of Process Results				
Utility or Value to Stakeholders				
Conformance Criteria for Each Level: (TBD)				

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