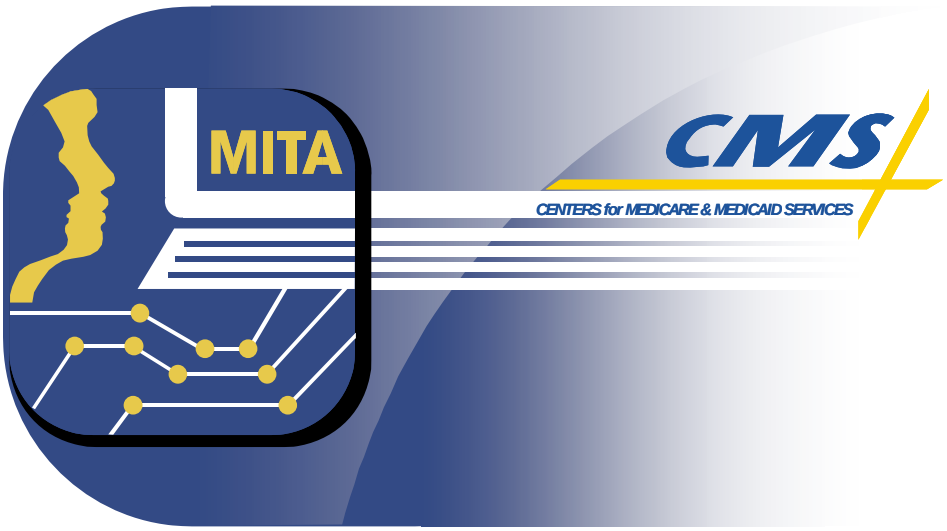

SAMHSA

Behavioral Health MITA

Business Process/Data Model Document

Version 1.0

Developed for
Centers for Medicare & Medicaid Services

Behavioral Health MITA

Business Process/Data Model Document

Version 1.0

Medicaid Information Technology Architecture

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Section 1 Introduction

This document introduces the Behavioral Health Medicaid Information Technology Architecture Business Process/Data Model (BH-BP/DM) and explains its role in the BH-MITA Framework. The BH-MITA framework provides a tool and potential guidance to State mental health (MH) and substance abuse (SA)–herein both referred to as behavioral health (BH)–agencies as they seek to improve their business operations and build systems that interoperate with each other and with Medicaid systems. This document draws extensively on previous work done by the Centers for Medicare & Medicaid Services (CMS) on the Medicaid Information Technology Architecture (MITA) Framework 2.0, March 2006.

The BH-MITA Framework model, in brief, presents a framework that describes business capabilities and technical enablers in the present (the As-Is), a vision of future business capabilities and technology enablers and integration in the future (the To-Be), and then creates a series of snapshots of how business improvements and enabling technology and integration might move an entity along the path from the current state to the potential To-Be state. This series of snapshots is called the Maturity Model, and provides BH agencies with both a target for further business transformation and technical improvements and a measure for how far along they are on the path to the ultimate vision of an integrated and interoperable business operation supported by enabling technology. The MITA Business Process Model provides the foundation for developing the vision, grounded in the business processes identified today.

The BH-BP/DM document builds on the CMS MITA Framework 2.0, available at http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp.

The MITA Framework 2.0 has three components: 1) the Business Architecture (BA), 2) the Information Architecture (IA), and 3) the Technical Architecture (TA). The BH-MITA project captures the key elements of the Business Architecture which describes the needs and goals of State BH agencies and presents a collective vision of the future. Project documents are described below:

- Landscape Document: Documents current business and technical capabilities (the As-Is state)
- Concept of Operations (COO): A broad vision of future business and technology (the To-Be state)
- Maturity Model (MM) Roadmap: A series of snapshots in a high-level roadmap that projects how business and technology will change along the way from the As-Is and To-Be states
- Business Process/Data Model (BP/DM): A description of the current operational processes for BH agencies
- State Self-Assessment (SS-A): Draws upon the BPM to help States assess their current business capability levels for each business process and select the future levels of improvement they seek to achieve.

The Business Process Model brings together the Business Architecture components of the BH-MITA framework to build towards the more detailed Information Architecture components.

This BH-MITA project develops the components of the BA, which set the foundation for the next phase of the framework, the Information Architecture (IA). The IA documents the major types of information needed to support the business processes and identifies and defines the information models, data repositories, and their relationships to the business functions. The BA and IA are connected and aligned through a set of information system requirements that are derived from the BA and documented by the IA. They are two different views of an integrated enterprise architecture. The Technical Architecture (TA) is derived from the IA and describes the current and future data and technical services, connectivity, specifications, and standards that support the BH enterprise architecture. See Figure 1-1 below.

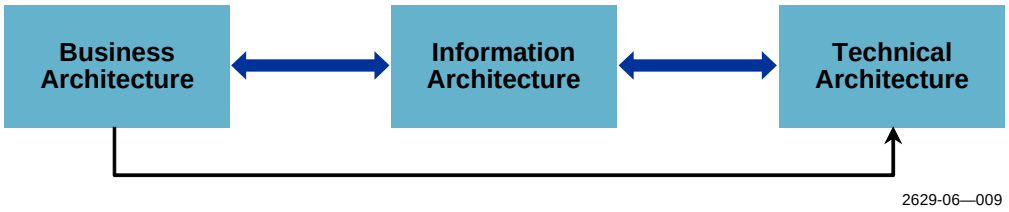


Figure 1-1 MITA Framework Architecture Relationship Diagram

See Appendix A for further discussion of these three MITA Framework 2.0 components and their relationships.

Figure 1-2 below shows the documents developed for this phase of the BH-MITA project, depicting the purpose of each document and relationships between them. The BH-BP/DM is in pink.

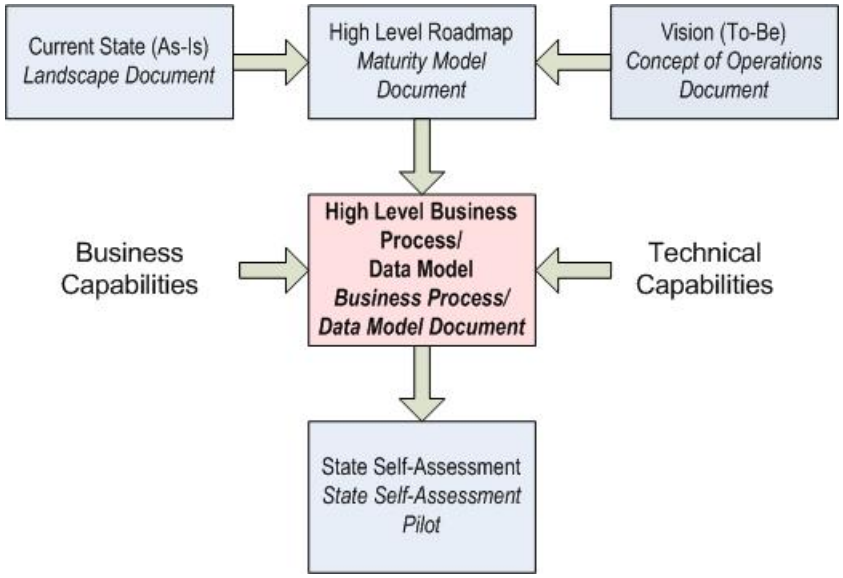


Figure 1-2 Document Relationships in the BH-MITA Project

The Business Process Model (BPM) provides a picture of the business needs and objectives that inform and drive the specific technical design to achieve the technical transformation needed to support the ultimate vision. The information in the BPM is required to build a detailed plan for the information systems to support those business processes. The BH-MITA BPM, draft form, is the foundation for developing the vision, grounded in the BH business processes of today. Like the MITA model/framework, the BH-MITA framework is dynamic and must be updated as changes occur.

1.1 Purpose of the Business Process/Data Model Document

The purpose of this BH-BP/DM document is to provide a start point for the further development of a baseline description of all the various business processes that make up BH operations today. This document essentially provides a "straw man" BPM intended to give BH agencies a leg up on developing a full-fledged, comprehensive BPM for behavioral health. This will require further work by SAMHSA and State BH agencies to fully describe and validate a common set of processes that support BH operations today. In the more distant future, the fully developed BPM will expand to describe new business processes that come online as the business matures (such as when BH and Medicaid agencies coordinate with other State and local agencies to create a "one-stop-shop" client intake process). Many business processes that States engage in today are expected to disappear in the future (e.g., funding reimbursement processes today will be replaced by direct messaging between a provider's system and bank and a payer's automated funding/reimbursement process/system).

The BH-BP/DM provides the foundation for a common operational reference point for State BH agencies.

This BP/DM document is also designed to introduce the BPM and its concepts to State BH leaders to facilitate their understanding and assist their participation in future stages of this project to develop a comparable and compatible architectural model for BH agencies.

1.2 What is the Business Process Model?

A Business Process Model (BPM) describes the steps an organization or business takes to perform its functions, including the events that initiate those processes (i.e., trigger events), and the results of those processes. A process-oriented business model best fits a framework designed to support all State agencies, each with its own organizational structure, policies, and operational procedures. The process-oriented approach views business operations cross-functionally and organizes the actions of the business as a set of activities that respond to business events. Opportunities for real process improvement and dramatic business change are more likely to emerge from this perspective as it "dismantles" existing organizational silos. The BPM does not care how the business is organized, who does the work, or where the work is performed. The focus is on the activity itself (i.e., what initiates the activity and what the activity produces). In this sense, the BPM offers a "one-size-fits-all" solution because it focuses on the core business process and not on how the activity is accomplished.

The Business Process Model identifies and describes the individual business processes of today, with old processes dropped and new ones added as the BH agency matures. The BPM is technology-neutral, focusing on what the process does, not how it is accomplished.

A complete business process definition provides:

- A high-level description of a business activity (a series of steps)
- The trigger (data) that initiates it
- The shared data that the activity uses
- The result (data) of the process

These business process descriptions will provide the foundation for developing data models that document the types of data needed to support each business process.

The Business Process Model describes a business activity, its triggers, the data involved, and the outcome of the process. The BPM is needed to build the data models that move the BH agency towards a plan for reengineering BH information systems.

The BPM at present is meant to apply to the State BH agency enterprise only. The BH-MITA BPM is a first cut at documenting the common operations of the BH enterprise as they exist in most States today. It lists BH business processes found in a typical State and organizes them into various categories of common interest or focus (e.g., Provider/Contractor Management, Client Management, and Operations Management). A fully developed BH-MITA BPM will provide a common reference point for State BH agencies. Agencies and their vendors can ultimately map their processes to the fully detailed BPM, which describes their business processes in a standard way using a common vocabulary.

The BPM is a work in progress. The MITA Framework 2.0 contains a baseline BPM and descriptions of 78 business processes for current Medicaid operations that can be viewed at http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp.

Section 2 Data Models

Data models serve as a blueprint or plan for building information systems, and as a tool that enables the reengineering of business processes and enterprise strategies. Data models will be used by BH system architects and designers to aid the development of interoperable BH applications, systems, and networks. It is only through the use of a shared data model that the States will achieve true interoperability.

A data model is not included in this BH-MITA project, but is described here to show how the BPM detail feeds into the next component (IA) in the overall framework.

Data models serve as a blueprint or plan for building information systems.

2.1 Data Model Types and Characteristics

There are *conceptual* and *logical* data models that share some common characteristics:

- **Entities.** A person, place, thing, organization, event, or concept of interest to the State and SAMHSA, and about which States store information (e.g., Client, Provider). In general, an entity must have the following characteristics:
  - An entity must have one or more attributes that distinguish between individual occurrences of that entity
  - An entity must have at least one relationship to another entity
- **Relationships.** Relationships depict the business rules/requirements by which two entities are joined. The interaction between entities in a relationship can be traced in either direction.
- **Definitions.** Definitions must be clear, precise, and unambiguous. They must identify and distinguish the item being defined from any other actual or possible item. Examples or exclusions may be used as needed to improve clarity.
- **Domains.** The specific business area or subject area to be applied to the entity.
- **Related standards.** Any standards related to the entity must be defined.
- **Entity-Relationship (E/R) Diagram.** The method by which a formal, graphical depiction of the model is produced.
- **Attributes.** An item of data, a fact, or a single piece of information about an entity (e.g., the attribute Client Birth Date provides information about the entity Client).

2.1.1 Conceptual Data Model

The Conceptual Data Model (CDM) provides a mechanism to bridge the gap between BH subject matter experts and IT architects and designers. The model depicts the major business information objects (subjects/entities) in their relationships to each other using business

terminology. In addition, the CDM provides the basis for an IT staff (e.g., BH-MITA, States, or vendors) to develop a Logical Data Model (LDM). The CDM also provides an initial mechanism for ensuring the completeness of the BPM and serves as a tool that enables the reengineering of BH business processes.

The CDM is a reference document that provides a high-level overview of the data and relationships used by a BH enterprise.

The CDM identifies subject areas and groupings of data important to the business and defines their general relationships. Examples of these groupings for BH-MITA are Client, Provider, Address, and Service. These groupings are called *entities* in data modeling terminology. The CDM also depicts the relationship between entities, such as a Client has an Address (see Figure 2-1). The model also shows whether this relationship is mandatory or optional and whether it is a one-to-one, one-to-many, or many-to-many, and references any associated data standards.

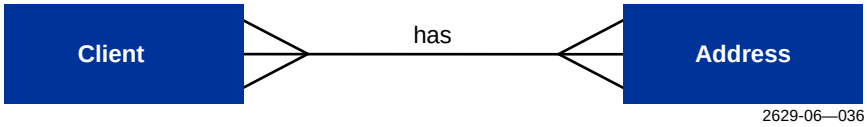


Figure 2-1 Simple Conceptual Data Model

2.1.2 Logical Data Model

The Logical Data Model (LDM) provides guidance and specifics to an IT staff (e.g., States or vendor) on how to design BH-MITA enterprise service interfaces. It is also used to develop the State's physical data model, which describes how data will be distributed to different processing nodes and how data will be structured to meet performance objectives in a specific physical implementation. The LDM provides a mechanism for ensuring the completeness of the BPM and serves as a tool that enables the reengineering of BH business processes. The LDM provides:

- Focus on what data comprises the organization, and not on what data is needed by the processes
- Facilitation of business-focused data analysis
- Aid in understanding enterprise-wide business rules and business data usage, as well as uncovering existing data defects, from a 360-degree view of a business
- A basis for performing data integration
- Contributions to improved data quality

The LDM documents the details of the data and relationships used by a BH enterprise. It can also be used as a requirements document for BH enterprise systems.

The CDM is a high-level construct that feeds into the development of the more specific LDM. An LDM presents a more detailed version of the CDM. Figure 2-2 represents a simple LDM.

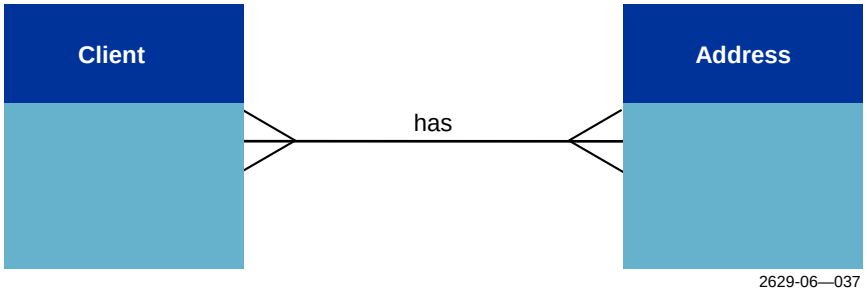


Figure 2-2 Simple Logical Data Model

In Figure 2-2, the Client entity has additional data details specified (e.g., ID, SSN, First Name, etc.). In data modeling, these additional details about a Client are referred to as *attributes*. Attributes can be specified as mandatory or optional. In addition, an attribute can be used to locate a particular entity in the system. Typically, a Client's data could be located by either using the ID or SSN, in which case both of these attributes would be labeled as *key attributes*. The LDM also references any associated data standards. Data organization rules are applied to the data model.

2.2 The BH-MITA Data Model

A BH-MITA Data Model is required to document the data and the characteristics of that data necessary to satisfy the needs of the BH enterprise. However, a BH-MITA Data Model was beyond the scope of the resources available for this phase of the BH-MITA project. Data models specific to the BH enterprise must be developed jointly by SAMHSA and the States. The data models depend on having a fully described BH-MITA BPM. Note that a BH-MITA Data Model will not contain information regarding a specific State's unique processes and data. It will be each State's responsibility to supplement a BH-MITA Data Model with its unique data requirements.

Section 3 Defining the Business Process

The following section defines the characteristics of a business process by providing baseline definitions, additional distinguishing qualities, and a template for capturing business process information.

3.1 What is a Business Process?

The business process is the lowest level element shown in the BPM. Levels above are clusters or groupings of processes. A business process is defined as a series of activities that are triggered by one or more events and lead to one or more results. All of the business processes contained in the BPM are described in a standard template that captures the Trigger[1], Result, and Business Logic. A Trigger event activates a business process, which is carried out in one or more steps, and produces one or more results or outcomes. For example, the business process Intake Client contains the following elements:

- One or more Triggers (e.g., new client visit, opening an intake screen), defined in terms of a data or time/schedule
- A series of Steps or Business Logic (e.g., validate data, assign client ID, check additional program and service eligibility), the individual steps/activities that occur between the Trigger event and the Result
- One or more Results (outcomes or outputs; e.g., admit client, request more information, determine what further assessments are needed), the data produced by the process

Figure 3-1 illustrates the components of the business process.

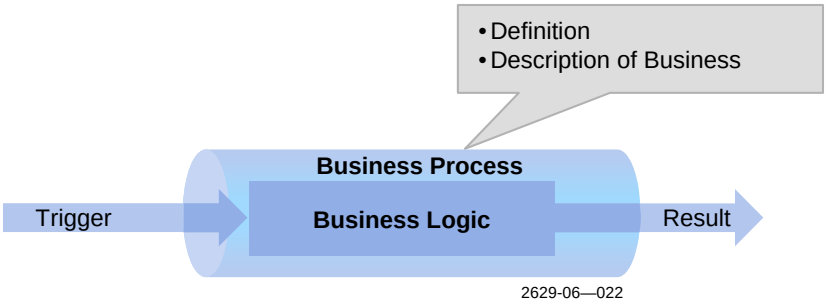


Figure 3-1 MITA Business Process Description

An example of a business process is Intake Client. The Trigger is opening and inputting data into an intake screen or form for a client seeking services. The Result is an outcome of "provide services", "additional information required", or "further assessment." The Business Logic steps

[1] Synonyms used in this chapter include: Trigger or Trigger event; Result or Outcome; Business Logic or Steps or Activities; Shared Data or Data at Rest.

can include validation of key data, verification or assignment of ID, checking for appropriate programs and services, and pointers to additional forms and assessments. Characteristics of the business process must be measurable. An example of a measurement is the time between the Trigger and the Result. Shared data used in the process may include the State's client data and external registries that can help identify other program participation or eligibility, such as for Medicaid.

A business process is a series of activities that are triggered by one or more events and lead to one or more results.

Ultimately, a complete BPM would document the following:

- A definition of each business process that describes the overall objective and purpose
- A definition of a performance measure for each business process, so that the same things are measured in the same way (i.e., what is measured to verify that the business process is achieving the capabilities expected)
- A definition of the data used to trigger the business process and the data contained in the Result — also called data in motion because 1) it is received from/sent to an external source (e.g., a BH agency receives initial client data from a referral), or 2) it is passed from one process to another (e.g., a BH agency enters intake data which then identifies the appropriate assessments to administer)
- A definition of the data used by the Business Logic steps internal to the process — this is called data at rest or shared data because the data is utilized or read, but not moved, changed, or updated as part of the process
- A definition of failure points where a business process may stop before completion

A fully developed BPM describes the collection of business processes that represents the typical operations of a BH agency today. These processes evolve over time: some are transformed, others are replaced or rendered obsolete, and new business processes will appear. Appendix B describes how to build complete business process descriptions and provides a template for capturing the appropriate type and level of information. Documenting the business processes in detail provides the BH agency with the foundation for describing the associated business capabilities.

See the BH-MITA Maturity Model document, Appendix B, for a detailed description of how to use the Business Capability Matrix to identify business capabilities for each of the business processes in the BH-MITA BPM.

3.2 How Business Processes Mature

Business processes described in the BPM are those in operation today. However, the BH-MITA Framework also eventually needs to show how typical processes can be transformed over time.

The Business Capability Matrix is the vehicle used to show this transformation. Figure 3-2 illustrates the relationship between the business process and the different levels of business capabilities. (See the BH-MITA Maturity Model document, Appendix B, for more information on the process for developing business capabilities).

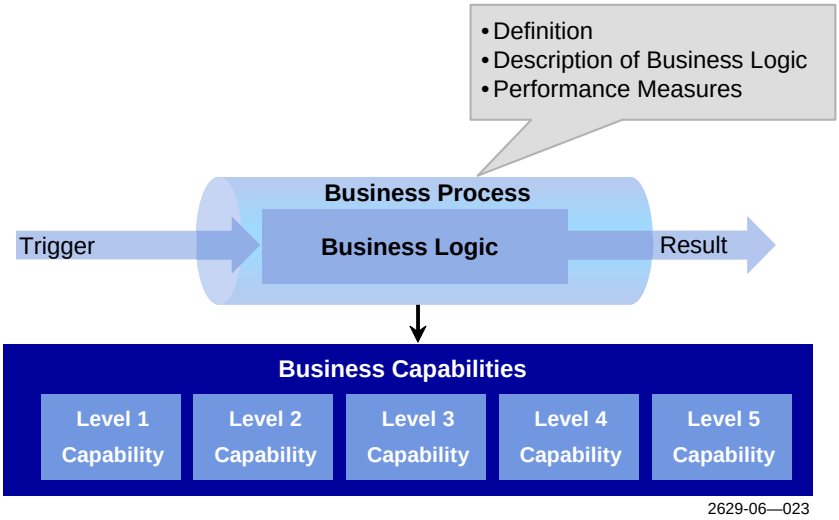


Figure 3-2 Business Processes and Business Capabilities

As an example, assume that Authorize Service is a business process that approves or denies payment for or delivery of a service based on evidence about the person's health status, medical needs, or other factors. The Trigger event is Receipt of Service Authorization Request. The Result is Authorization Status (e.g., denied, approved, or requires more information). The steps may include authentication of requestor; validity of service; appropriateness of service for client's condition, needs, age, or gender; and service or dollar limits.

A business capability describes a business process at a specific level of maturity. Each new business process has an initial capability. Business capability statements include definitions of qualities that represent measurable differences between each level. The business capabilities associated with the various business processes can have from one to five Maturity Levels, as reflected in Figure 3-2 above. Maturity Level 1 reflects the current capabilities commonly seen today. The other levels show progressive advances in the timeliness, effectiveness, and efficiency of the business process and process capabilities. Both the old and the new business processes remain in the BPM because while some States may have implemented the new process, other States may continue to use the older process.

A business capability describes a business process at a specific level of maturity. The business process Intake Client has a current business capability, a future business capability, and business capabilities that are expected along the transformation path.

Section 4 Business Process Model Hierarchy

The following section describes a possible BH business process hierarchy by describing and organizing a set of common business processes.

4.1 The Business Process Hierarchy

The business process hierarchy is a structure that groups together business processes that have a common purpose and share data. Provider/Contractor Management, for example, focuses on provider/contractor outreach, registration, and information maintenance (as distinct from payment or auditing) and "owns" a designated set of provider/contractor demographic data. Grouping business processes allows a series of more specific breakdowns to a single business process, the lowest level within a business area. Figure 4-1 shows the highest level (Tier 1) of business areas (each of which are formed by one or more business processes) in the BH-MITA BPM.

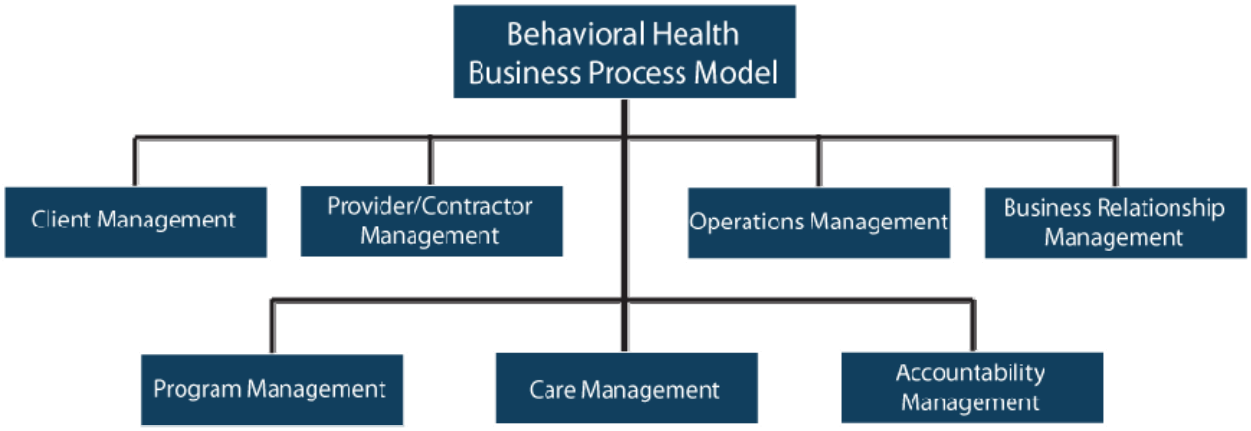


Figure 4-1 BH Business Process Hierarchy

Figure 4-2 illustrates the additional tiers, hierarchy, and groupings used by the BH-MITA BPM. This figure is a simplified version of the BPM. The lowest level business process appears in different tiers depending on the complexity of the business area. In less complex business areas, the business process appears at Tier 2 or 3. Although the BH-MITA BPM presents a way to organize business processes, States can choose to organize their individual business processes differently (and, of course, assign them different names).

The title of a business area or other business process grouping level appears as a noun (e.g., Operations Management, Payment Management). Each unique business process appears at the lowest tier and is shown as a verb + object (e.g., Intake Client, Authorize Treatment Plan).

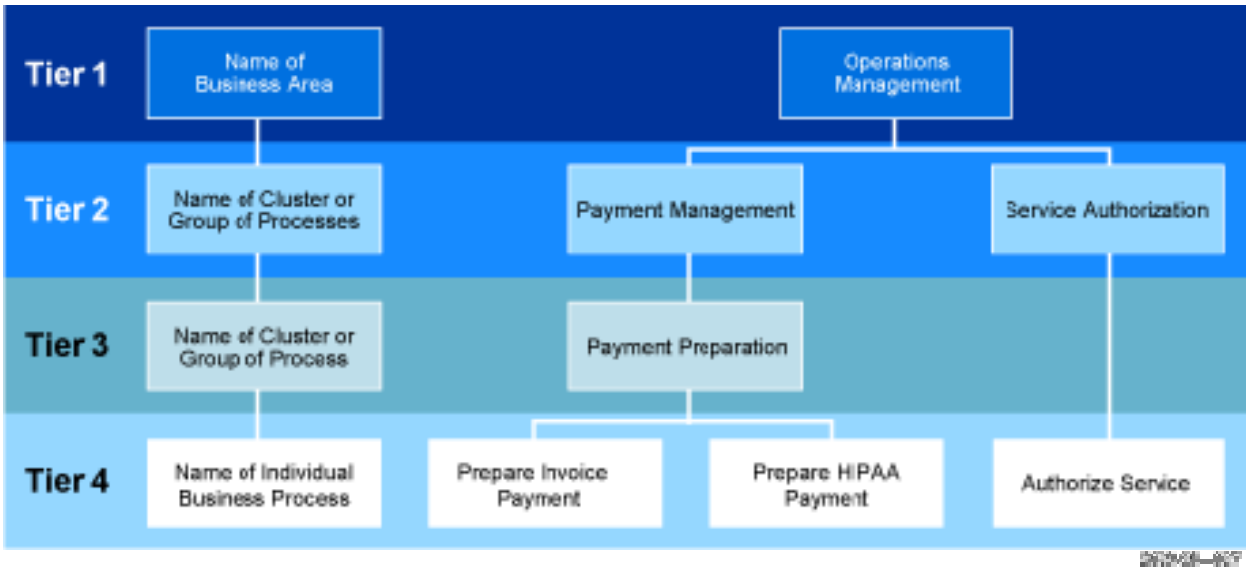


Figure 4-2 MITA Business Process Model Hierarchy and Levels

4.2 The BH-MITA Business Process Model

In October 2007, SAMHSA/CMS hosted a facilitated session that brought together a group of people from Federal agencies, Federal BH contractors, and national associations representing BH agencies (National Association of State Alcohol and Drug Abuse Directors, NASADAD; and the National Association of State Mental Health Program Directors, NASMHPD) to explore ways that the MITA Business Process Model could be adapted to meet the needs of BH agencies. The key output of this meeting was reviewing the MITA Business Process Model hierarchy and making revisions as needed to create an initial BH Business Process Model hierarchy.

The high-level BH-MITA business areas proposed are depicted in Figure 4-1 above. The content and purpose of each BH business area are discussed below, with graphics that decompose each business area into a set of more specific business processes. The business processes that comprise each business area and constitute the BPM are located in Appendix C.

4.2.1 Client Management Business Area

The Client Management business area consolidates many outreach, communication, and information management functions into a single, generic business process.

The Client Management business area is a collection of business processes involved in managing client data and communications, and focuses on outreach to current and potential clients, capturing and maintaining client demographic details, and supporting clients' need for service information. The goal for this business area is to manage client data and communications to

improve program participation and healthcare outcomes; future transformation is towards more client self-directed decision making (see Figure 4-3).

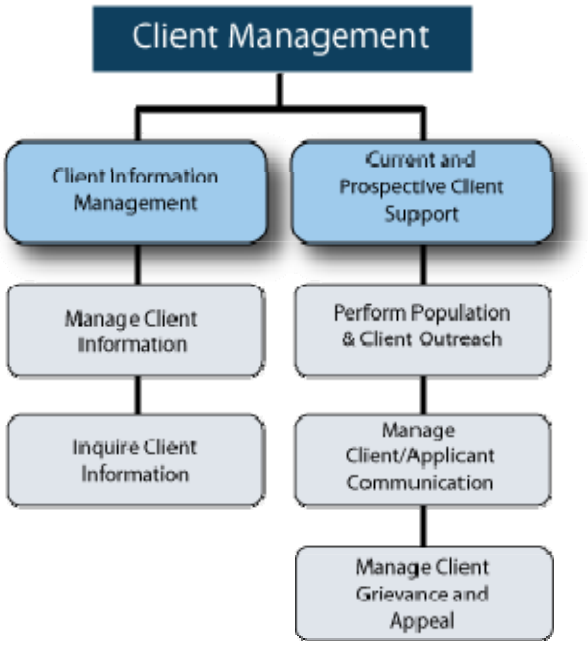


Figure 4-3 Client Management

4.2.2 Provider/Contractor Management

In BH agencies, provider and contractor management have essentially the same associated processes. Given the lack of an insurance intermediary, an MH/SA agency primarily contracting with providers may merge contract functions with provider management.

The Provider/Contractor Management business area is a collection of business processes that focus on recruiting and managing potential providers/contractors, maintaining information on and communications with providers/contractors, and provider/contractor compliance monitoring. This business area encompasses the many types of BH service delivery contracts (e.g., provider agencies, BHOs, non-medical support services, primary care physicians), the many types of agency administrative services contracts (e.g., data analysis, use of third party payment systems), and State contracts for services via intermediaries such as counties, MH/SA networks, and community-based organizations. All these are treated as a single business process in this model (see Figure 4-4) because the activities are the same, even though the input and output data and business rules may differ.

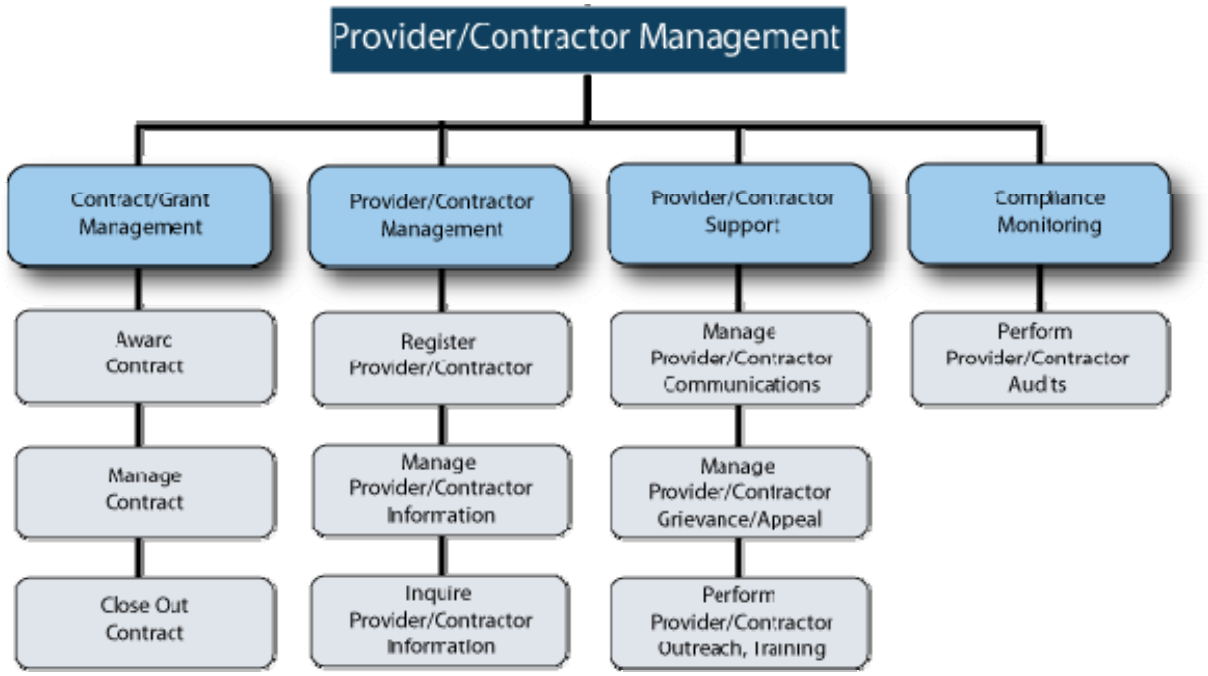


Figure 4-4 BH Provider/Contractor Management

The goal of this business area is to maintain a robust client services network and administrative support services that meet the needs of the client, the agency, and provider/contractor communities.

4.2.3 Operations Management

Operations Management for BH is focused on managing overall BH funding and payment for services.

The Operations Management business area includes operations that support the funding and payment of services and service providers. It supports funds management and the receipt and distribution of funds and payments, and all information associated with agency funding to and from all sources. Most States currently have automated operations that support at least some of these activities. Common activities include allocating and monitoring grants and funding distribution, and managing and facilitating payment processes both internally and with State Medicaid and other State payer programs (see Figure 4-5).

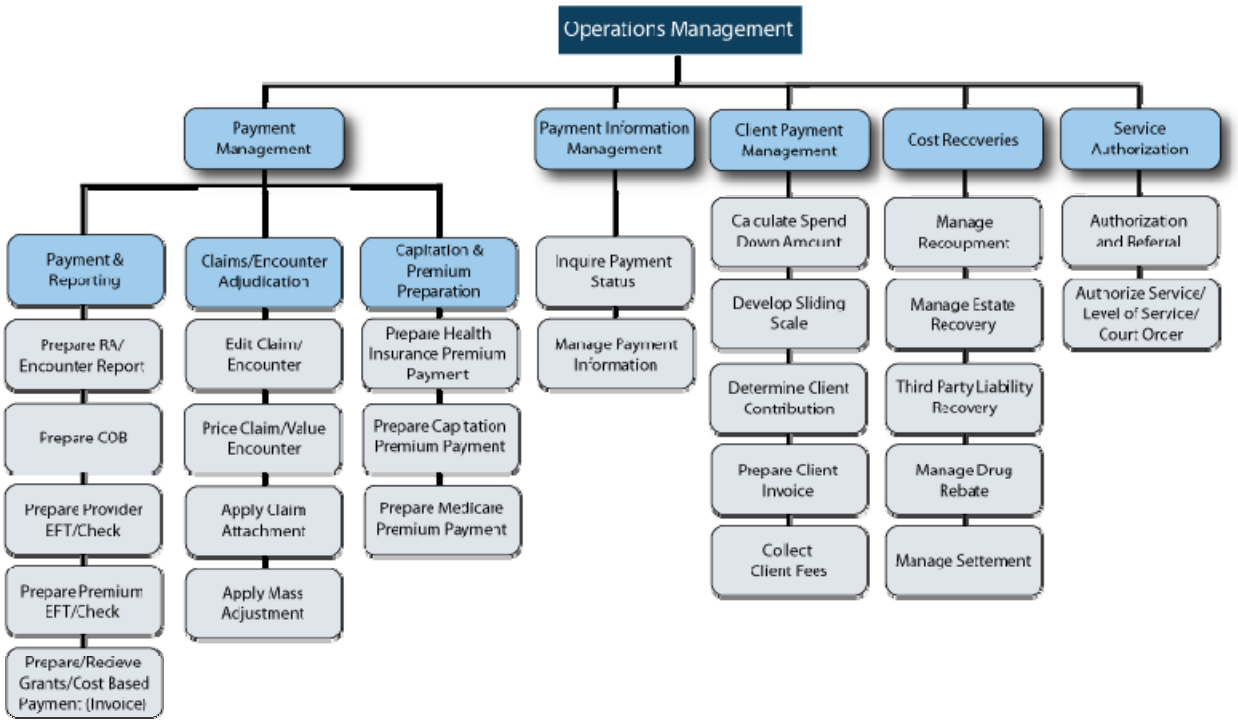


Figure 4-5 BH Operations Management

4.2.4 Program Management

BH Program Management has a strategic focus on managing overall BH population needs, outcomes, and services, and on improving accountability for the future.

The Program Management business area houses the strategic planning, policy making, monitoring, and oversight activities of the agency. It includes a wide range of planning, analysis, and decision-making activities, including service needs and goals, health care outcome targets, budget analysis, accounting, quality assessment, performance and outcome analysis, continuity of operations plan, and information management. These activities depend heavily on access to timely and accurate data and the use of analytical tools. This is the heart of the BH enterprise and the control center for State BH operations (see Figure 4-6.).

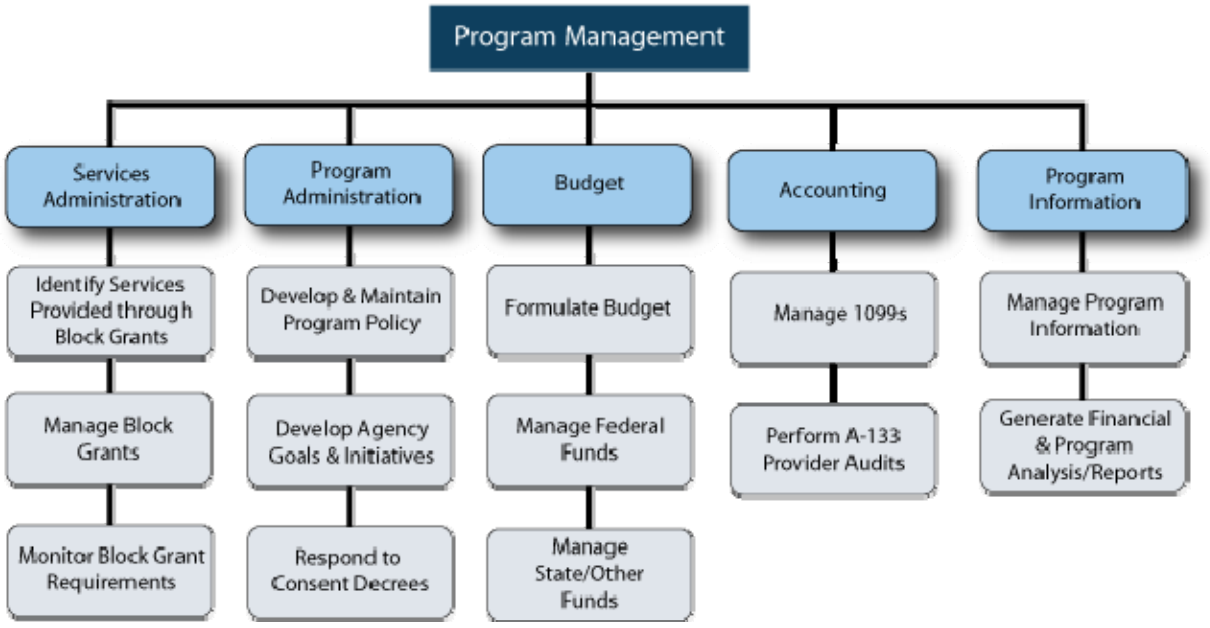


Figure 4-6 BH Program Management

4.2.5 Care Management

The Care Management business area is more detailed in BH agencies than in the Medicaid program, since care management and client support are critical to successful BH outcomes.

The Care Management business area includes processes that support individual and population care management and prevention. It contains a broad set of business processes related to client care (e.g., identify and manage special populations, develop and implement the treatment plan, monitor and manage treatment and services, and manage client outcomes), and collects information about these activities (see Figure 4-7.)

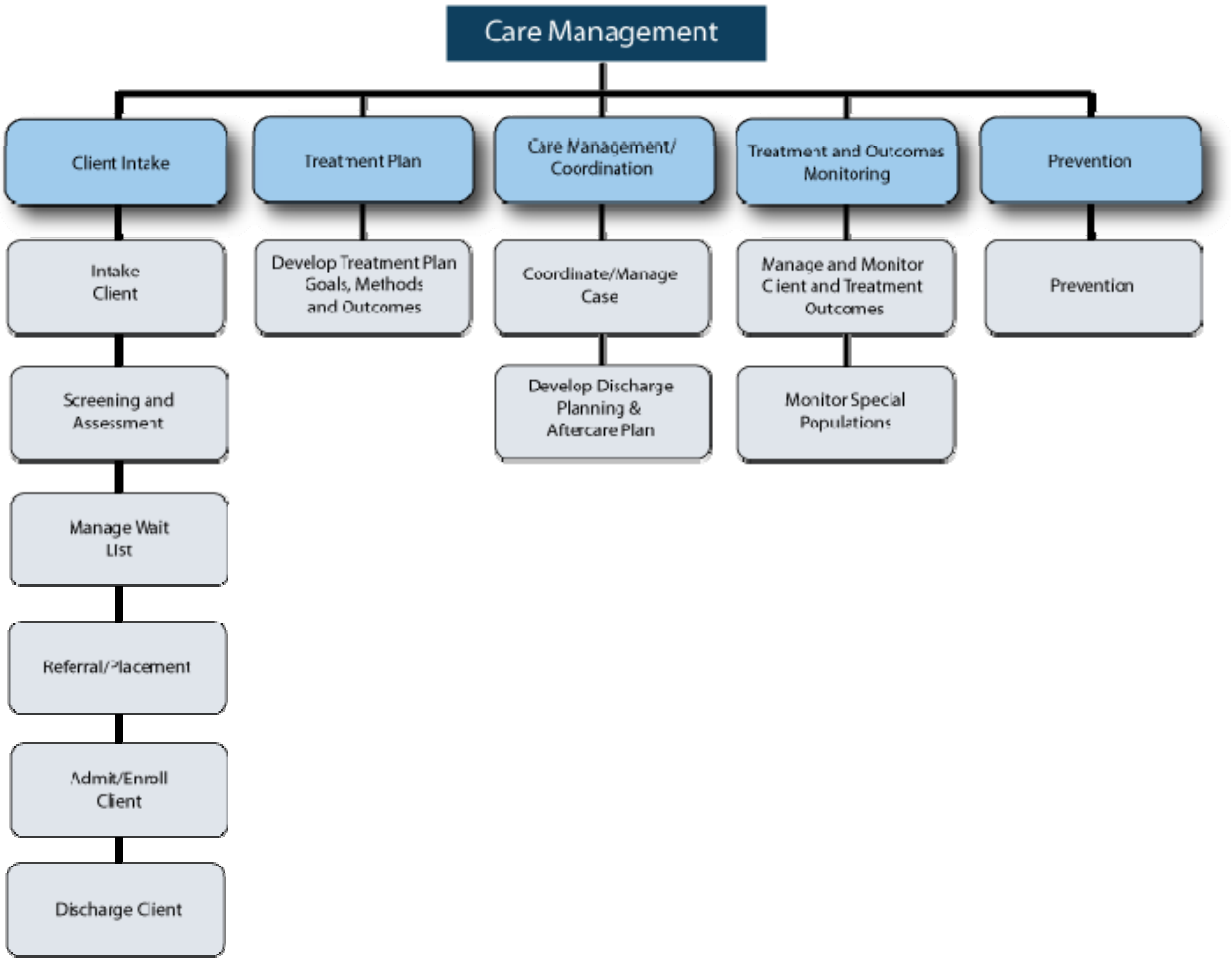


Figure 4-7 BH Care Management

4.2.6 Business Relationship Management

The Business Relationship Management business area primarily relates to facilitating data exchange between business partners. It may not be a major concern for BH agencies at present, but will gain importance as electronic data exchange becomes more common.

A major focus of the Business Relationship Management business area is the agreements and conditions for data exchange, particularly between government business partners. Currently, this business area is often represented in many States as a component of Program Management. It is presented here as a separate business area because collaboration between in-State agencies and inter-State and Federal agencies is increasing in importance and is integral to electronic information exchange. This business area contains the standards for interoperability, establishment of interagency service agreements, identification of the types of information to be exchanged, and security and privacy requirements (see Figure 4-8).

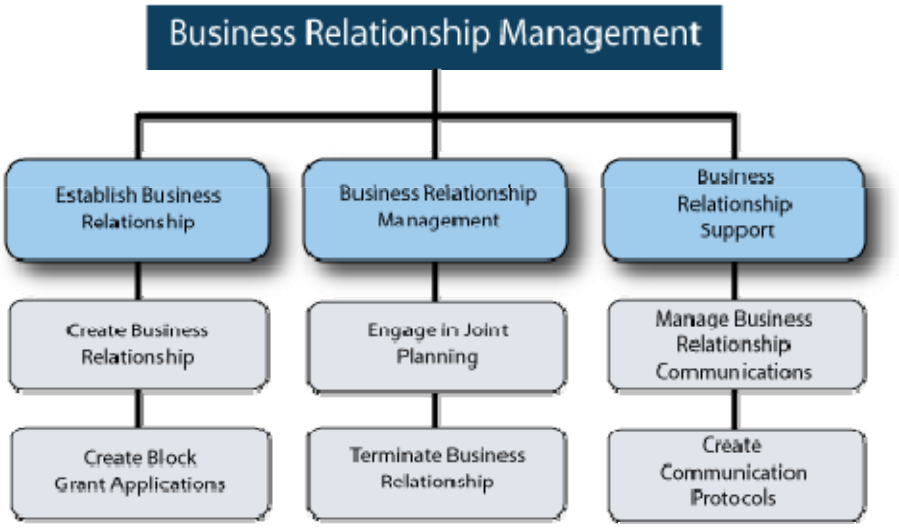


Figure 4-8 Business Relationship Management

At present, most data exchange and communications between agency partners are still done manually. However, electronic data exchange and intra-agency service agreements are becoming more commonplace. In the future, the goal is to enable data exchange on a national scale based on agreements between Federal, State and local entities.

4.2.7 Accountability Management

The Accountability Management business area is focused on appropriate service provision, clinical performance, and adherence to reporting and funding requirements.

The Accountability Management business area incorporates those processes that focus on program monitoring and compliance (e.g., auditing and tracking appropriateness and quality of care, adherence to program and grant requirements, adequate documentation, and fraud and abuse). This business area collects information about individual providers/contractors, clients, and services that are used for developing Federal, State, and program measures related to outcomes, performance, quality, and others. This process will mature with access to clinical data that improve the capability for monitoring and reporting quality and identifying fraud and abuse (see Figure 4-9).

Figure 4-9 Accountability Management

Section 5 The BH-MITA BPM and Next Steps for the BH-MITA Framework

This section describes the BH-MITA BPM and discusses the next steps in the further development of the BH-MITA Framework. Ultimately, the BH-MITA Framework is about planning and managing change, so that State BH agencies can continuously improve the way they manage and deliver services to clients and providers/contractors, improve outcomes, reward performance, and respond dynamically to requests for information. As the health care industry, both public and private, is always evolving, BH-MITA will always be a work in progress.

The Business Processes in this document are only rough drafts to provide a starting point for complete Business Process Models and Data Models for BH-MITA. Further work by SAMHSA and State BH agencies is essential to build a more accurate and comprehensive picture of the common BH processes that form the BH enterprise.

5.1 The BH-MITA BPM

The BH-MITA BPM is a simplified version of the MITA BPM that is intended to assist States in developing a detailed, BH-specific model. The BH-MITA BPM, in Appendix C, lays the foundation for replicating the MITA BPM development process, using intensive State involvement to flesh out the universe of processes, elements, and detail for a complete picture of current BH business operations. The BH-MITA BPM builds off the MITA Framework 2.0, incorporating some information in the recently released MITA BPM 2.01, found at the HL7 MITA Project site at http://hl7projects.hl7.nscee.edu/docman/?group_id=40. It also uses input gathered in October 2007 from select representatives from Federal agencies, Federal BH contractors, and national BH agency associations who explored how to adapt the MITA BPM for BH agencies.

The BH-MITA BPM draws on the detailed process and capability information from the MITA BPM and Business Capability Matrix (BCM) documents where process similarities exist. For example, many of the operational processes, such as providing payment, creating and terminating contracts, and managing client, provider, and contractor information, are essentially the same for BH agencies as for Medicaid programs. Information drawn from the MITA BPM and BCM was often substantially revised to reflect BH terminology and operations, to simplify content for comprehension, and to fill in some gaps in the MITA models. Where there were no MITA equivalents, new process descriptions were developed following the MITA model using contractor experience, web research, and State and Federal input.

The simplified BH-MITA BPM provided here includes elements of both a MITA BPM and BCM as described below:

- A high-level description of a business activity (a series of steps)
- A general description of the shared data that the activity uses

- A series of five maturity levels highlighting key elements of change in the associated business capabilities

The format of this BH-MITA BPM was chosen as a way to provide the States with direction to develop a complete BPM and BCM, which are both necessary for progressing to the next steps in the framework. The business capability levels focus on describing the distinct technological and operational progress over time as agencies progress their business operations and technologies towards the future vision. Key attributes that are developed and integrated over time at each level are quality edits, adopting standards, cross-program collaboration/one-stop-shopping, access to clinical information electronically, and nationwide electronic exchange of information. A sample table is replicated below in Table 5-1.

Table 5-1 Sample BH-MITA BPM Table

Business Relationship Management (BRM)

BRM Manage Business Relationship Communications					
Item	**Details**				
Description	The ***Manage Business Relationship Communication*** business process produces and assures routine and ad hoc communications between the business partners.				
MITA Reference	Source Process Name: *Manage Business Relationship Communication* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Content for communication				
BRM Manage Business Relationship Communications: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. Communication is not coordinated among multiple, siloed programs and not systematically triggered by agency-wide processes. This Level complies with agency requirements.	The process incorporates Web interfaces; basic business rules; and state agency specific standards. Routine communications with business partners are standardized and automated within the agency. This Level includes additional data and quality edits.	The process operates through virtual access to business partners. Communications are standardized within the agency and coordination cross agency results in improved efficiencies. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Business partner communications are handled through HIEs statewide, and regular communications are automatic. All health care agencies collaborate in communications between agencies and among all business partners statewide. This Level adds clinical data.	Business partner communications are handled through HIEs nationally. Nationwide collaborations streamline communications with business partners anywhere in the country. This Level adds nationwide technical interoperability.	

Note that the BH-MITA BPM in this document is NOT equivalent to the MITA 2.0 BPM; this BPM only provides a start point for BH agencies to create a comprehensive description of the business processes involved in BH operations today. The MITA 2.0 BPM required extensive review and revision by states to improve and refine its completeness and accuracy, which is a moving target over time. This BH-MITA project did not include sufficient time or resources to carry out an extensive information collection, revision, and validation process with state BH

agencies, so the BH-MITA BPM provides a "straw man" model intended to facilitate BH agencies' development of a full fledged, comprehensive BH BPM. This will require further work by and ongoing involvement of both SAMHSA and state BH agencies to achieve the next level of business process description and completeness as reached in the BPM in the MITA Framework 2.0.

5.1.1 Next Steps: BH-MITA Business Process Model

The BH-MITA BPM presented here requires additional development by the States and SAMHSA to adequately represent BH operations for technical development and planning purposes. A complete BH-MITA BPM identifies all the major BH business processes commonly found in most States. This BH-MITA BPM presents a start point for building a comprehensive, common set of BH business processes, so it is important to have this "starter kit" validated by the community of BH agencies and stakeholders.

The next steps to further develop the BPM are described in Appendix B, adding more detailed definitions and defining the process triggers and results. A more robust BPM will allow the development of more targeted BCM, as described the BH-MITA Maturity Model document, Appendix D, which will assist States and vendors to assess their current systems and plan for enhancements, upgrades, or replacements. Those detailed business process definitions will allow all BH agencies to identify their business processes within the context of BH-MITA.

Using the MITA material provides BH agencies a jump start on developing a BH-specific BPM, but additional state and federal involvement, and time, is needed before a fully comprehensive BH BPM can be realized. Developing a complete BPM is a lengthy and iterative process. CMS just released version 2.01 of the MITA BPM, two years after the MITA Framework 2.0 BPM was published. An accurate and comprehensive BPM is critical to the BH-MITA development and planning processes. To achieve this, BH-MITA requires a new collaborative effort between States and SAMHSA to review and improve the business process descriptions and develop a detailed BH-MITA BPM, similar to the state collaboration used by MITA through the National Medicaid EDI HIPAA workgroup (NMEH). Consensus is essential for the BH community to be able to use the BPM as a springboard for developing sharable business services. (See MITA Framework 2.0, Part III Chapter 4, Business Services.)

The BH-MITA Framework calls for a BPM and BCM that contain the specifications of data groupings, data objects, and attributes. This is a next step in the evolution of the BH-MITA Framework.

5.2 Next Steps for the BH-MITA Framework

The goal of the BH-MITA Framework is to deliver the foundations of a starter kit for a controlled State BH agency transformation. This BH-MITA project's purpose has been primarily to create the documentation for the Business Architecture (BA) portion of the BH-MITA Framework. The documents that comprise the BA and this BH-MITA project include:

- The Concept of Operations (COO), documentation of the BH vision of the future and the target for BH technical and operational development.
- The Maturity Model (MM), documentation of the process to develop possible stages along the way as the BH enterprise moves from operations as they are today to the operations of the future.
- The Business Process Model (BPM), initial draft documentation of proposed BH Business Areas and Business Processes, and a process document for further development and refinement of the business process descriptions.
- The Business Capability Matrix (BCM), a process document (combined with the BPM in this document) for developing business capabilities at each Maturity Level.
- The State Self-Assessment (SS-A), which establishes the process for conducting a high-level state self-assessment (not yet completed)

All of the above documents created for BH-MITA require review and validation by state BH agencies to ensure a solid foundation for the next component required to build a complete BH-MITA framework. States, SAMHSA, vendors, and other relevant stakeholders must work together to validate, complete, enhance, and refine the information produced for each step in the process to provide the necessary guidance to States needed to progress towards the ultimate vision. A completed BH-MITA framework can then be used by BH managers, system architects, and designers to create more specific State models and documents that will aid the development of interoperable BH applications, systems, and networks. It is only through the use of shared models that the States will achieve true interoperability.

5.3 Summary

The BH-BP/DM is designed to provide a starting point to identify the major BH business processes common to most States. This BH-MITA BPM only establishes an initial foundation from which to build a common set of BH business processes. It is important to have this straw model validated by the community of BH agencies and stakeholders, which States, SAMHSA, and other BH stakeholders can accomplish through collaborative efforts. Further development of the BP/DM will expand its usefulness in specifically identifying and defining all current BH data and relationships, and provide a tool for ensuring the completeness of the BPM. When fully developed, the BH-MITA BPM can be a reference document that provides a high-level description of the data and relationships in a BH enterprise.

The business capabilities that are derived from and support each business process allow States and vendors to assess their current systems and plan for enhancements, upgrades, or replacements. States will need to extend the BH-MITA BP/DM with their unique requirements to develop and help align their models with the BH-MITA BPM.

States and vendors can refer to the BP/DM to document and clarify their understanding of Business Capabilities. States will use the business capabilities in their self-assessment with the BP/DM as a reference.

Appendix A Relationships between the MITA Business, Information, and Technical Architectures

The MITA Framework 2.0 contains three sections: Business Architecture (BA), Information Architecture (IA), and Technical Architecture (TA).

- The **Business Architecture** defines the information needs for the enterprise. The BA is essentially high level and descriptive, describing current business operations to the process level, framing a vision of future operations, and creating process stages as maturity level targets along the way between current operations and the operational vision. The BA is technology neutral to focus attention on the business process and how it evolves over time.
- The **Information Architecture** translates and defines the information needs of the BA into the data specifications that inform the TA. The IA adds greater specificity in detailing process relationships and the data utilized in each relationship both for the present and for the future. The IA is also technology neutral.
- The **Technical Architecture** creates the data specifications needed to achieve each level of maturity. The TA uses that data and process specificity in the IA, along with the vision and the maturity level stages, to plan the specific technical approaches needed to actualize the envisioned targets and, ultimately, achieve the future operational vision.

As shown in Figure A-1, the BA is linked to the IA and the TA. These sections build sequentially upon one another, developing greater specificity for certain areas in each section. Business processes developed as part of the BA map to the Conceptual Data Model, and business capabilities map to the Logical Data Model; both models are part of the IA. The TA describes the technology approaches that can achieve the different levels of maturity for the business processes and business capabilities. In addition, the TA describes strategies and solutions to implement those capabilities.

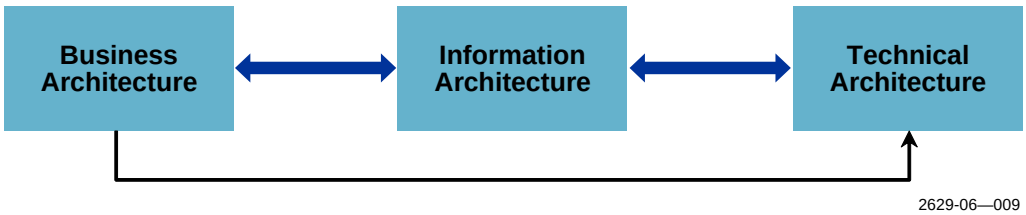


Figure A-1 MITA Framework Architecture Relationship Diagram

A.1 Business Architecture Components

Table A-1 summarizes the components of the BA. The Business Architecture sets the foundation for the framework by documenting and defining current business operations, a vision of future operations, individual business process and data used, and providing a method for state

assessment of their current business operations and IT use. For more detail on these components for the BH-MITA project, please consult the other BH-MITA documents.

Table A-1 Summary of the Business Architecture Components

Component	Description	Role in the BA
Concept of Operations	The COO presents a vision of transformation for State BH agencies. It describes how stakeholder roles (State operations, SAMHSA, providers, clients, and others) will change, how information will improve, and what will assist in the transformation. It also provides a model for the As-Is and To-Be Medicaid business operations that are reflected in the BPM and the To-Be business capabilities. The vision is based on input from States, SAMHSA, and other entities.	The vision lays the foundation for the transformation of the BH enterprise. It sets the targets for the maturity model and business capability improvements. The COO is the "big picture" of the BH-MITA Framework.
Maturity Model	The MM defines the boundaries for the levels of transformation, translated into the BH enterprise context. The MM uses five levels of maturity evolving over a 10+ year period. The MM shows how the BH mission and objectives will evolve, how BH agency operations will change, and how to measure the maturity level.	The MM provides a framework for showing how the vision of BH operations (i.e., the COO) will be realized over time.
Business Process Model	The BPM is a generic representation of the hierarchy of business processes for common operations found in most States today. The focus of BH-MITA is on the end business process rather than the higher level groupings. The model is a synthesis of input from States, SAMHSA, and other entities.	The BPM provides a generic description to bring States to a consensus regarding the basic business processes that they have in common.
Business Capability Matrix	The BCM is a grid that shows each generic BH business process as it exists today and as it may be transformed over time. The business capabilities express measures of timeliness, efficiency, effectiveness, and other qualities.	Each business capability at each level is traceable to the MMM. It is the primary output of the Business Architecture.
State Self-Assessment	The SS-A is a process in which the State will map its business processes to those in the BPM and assign a level of maturity to each business process according to the BCM. This activity allows each State to determine (1) the current level of maturity of each business process and (2) a strategy for improving some or all processes over time.	The SS-A is a practical strategy used by States to compare their operations with the BH-MITA BPM and BCM to assess current business capabilities and target future improvements.

Figure A-2 shows the interrelationships among the BA components.

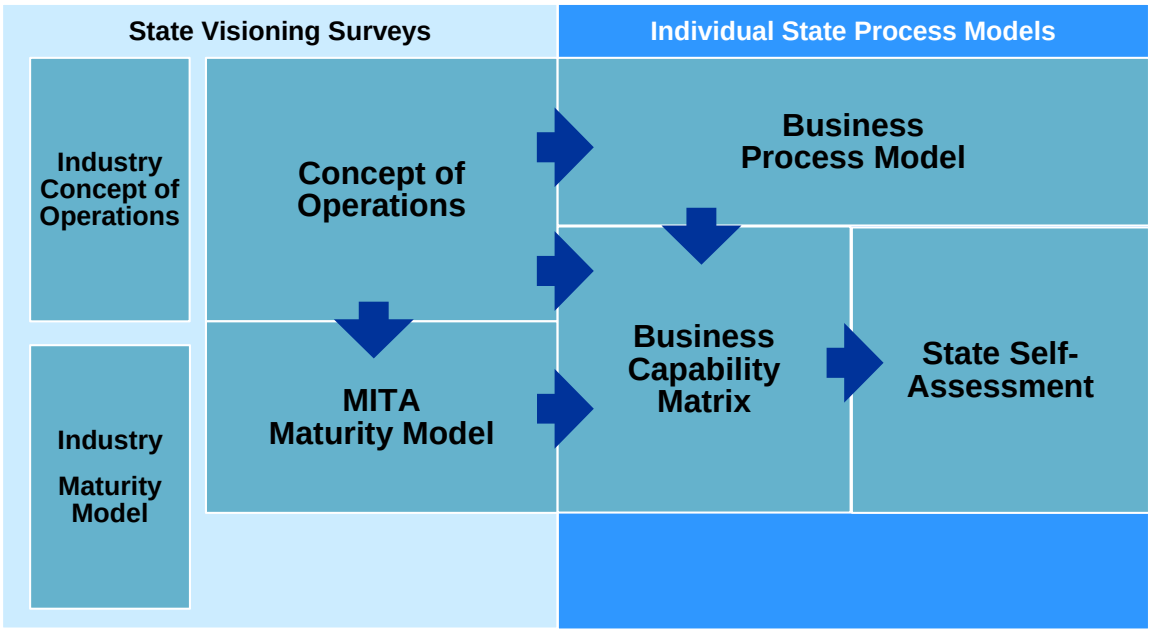


Figure A-2 Business Architecture Components

The BA components are interrelated as follows:

- The COO serves as a model to frame a vision for BH agencies of improved healthcare outcomes and operational efficiencies. It establishes the future To-Be vision that becomes the goal of the BH enterprise transformation. The COO provides the vision for the MM. It also supplies a model for the BPM hierarchy.
- The MM uses a common industry approach to describe the differences between five levels of progressive maturity, ranging from the As-Is level to a 10+ year To-Be level. The MM is the point of reference used by the BCM to describe the levels of maturity for a business process.
- The BPM describes current, As-Is State BH operations.
- The BCM uses the five levels of maturity described in the MM and the COO vision to create up to five levels of maturity for each business process. (A Level 3 business capability describes how a business process is changed and improved at a midpoint stage.)
- Finally, the SS-A draws upon the BPM and the BCM to assess its current business capability level for each business process and select future levels of improvement it seeks to achieve.

A.2 Information Architecture Components

Table A-2 summarizes the components of the IA. The Information Architecture builds off of the BA work and further documents the major types of information needed to support the business processes, and identifies and defines the information models, data repositories, and their relationships to the business functions to create the detailed documents necessary technical transformations.

Table A-2 Summary of the Information Architecture Components

Component	Description	Role in the IA
MITA Framework 2.0 Part II Chapter 2 — Data Management Strategy	The DMS is an enterprise wide data strategy that addresses the business flow of data. It facilitates the development of information/data that can be effectively shared across a State agency's enterprise boundaries to improve mission performance. It involves architecture, modeling, standards, metadata, management, interoperability, security and privacy, access methods, quality, and performance measurement. The three key parts of the MITA DMS are: ▪ Data Governance ▪ Data Architecture ▪ Data-Sharing Architecture	Provides a tool to help States transition their current information architecture to a MITA IA, to ultimately result in lower costs, improved outcomes, and reduced errors. The MITA DMS also provides a roadmap for States to use as they transition their enterprise from one level of maturity to the next.
MITA Framework 2.0 Part II Chapter 3 — Conceptual Data Model	The CDM represents the overall logical structure of the data, independent of any software or systems, and provides a formal representation of the data needed to run an enterprise or business activity. The CDM identifies subject areas and groupings of data important to the business and defines their general relationships. The CDM must have the following data: ▪ Entities ▪ Relationships ▪ Definitions ▪ Domains ▪ Related standards ▪ Entity-Relationship (E/R) Diagrams	Provides a tool to: ▪ Bridge the gap between agency subject matter experts and IT architects and designers ▪ For an IT staff (e.g., States or vendors) to develop a LDM ▪ Ensure the completeness of the business model and serve as a tool that enables the reengineering of agency business processes

Component	Description	Role in the IA
MITA Framework 2.0 Part II Chapter 4 — Logical Data Model	The LDM is derived from the CDM but contains more details, and references any associated data standards. The LDM shows data subject areas broken down into the data classes and attributes needed for one drilled-down business process, as well as the relationships between them. Data organization rules are also applied to the data model. The data modeling term used for the application of these rules is Normalization. The objective of an LDM is to have a fully attributed and normalized data model. The parts of the MITA LDM are as follows: ▪ Entities ▪ Attributes ▪ Relationships ▪ Definitions ▪ Domains ▪ Related Standards ▪ Entity-Relationship (E/R) Diagram	Provides guidance and specifics to an IT staff (e.g., States or vendor) on how to design MITA enterprise service interfaces. It is also used to develop the State's Physical Data Model that describes how data will be distributed to different processing nodes and how data will be structured to meet performance objectives in a specific physical implementation. The LDM provides a mechanism for ensuring the completeness of the business model and serves as a tool that enables the reengineering of agency business processes. It is only through the use of a shared data model that the States will achieve true interoperability.
MITA Framework 2.0 Part II Chapter 5 — Data Standards	The data standards identify the applicable standard for each MITA data element. Key elements of a data standard are data element names, definitions, data types, and formatting rules. Data standards describe objects, features, or items that are collected, automated, or affected by the business processes of a State agency's enterprise. MITA data standards fall into two major categories: structure data standards and vocabulary data standards.	Enable the sharing or exchange of information in a way that guarantees the mutual understanding of what is represented within that information.

Figure A-3 shows the interrelationships among the IA components.

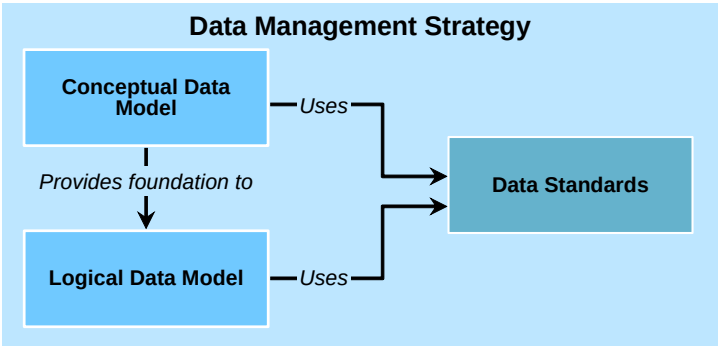


Figure A-3 IA Component Relationships

In summary, the four IA components provide an integrated architecture that provides the standardization, data sharing, and interoperability required by the various State enterprises. The relationships between those components are described below.

- The DMS provides a structure that facilitates the development of information/data that can be effectively shared across a State's BH enterprise boundaries to improve mission performance. The DMS addresses fundamental areas necessary to enable information-sharing opportunities and to position State BH agencies to operate in an environment of global information.
- The CDM represents the overall logical structure of the data, which is independent of any software or data storage structure, and provides a formal representation of the data needed to run an enterprise or business activity.
- The LDM shows data subject areas broken down into the data classes and attributes needed for one drilled-down business process, as well as the relationships between them. The LDM identifies all of the data elements that are in motion in the system or shared within the Medicaid enterprise.
- The data standards identify the applicable standard for each BH-MITA data element. The BH-MITA data standards are a collection of standards applicable to the administration and operation of Medicaid enterprise data.

For more detail on these components, see the MITA Framework 2.0 at **http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp.**

The MITA IA is technology-, organization-, and location-neutral. MITA does not address these aspects of the implementation, because they are the responsibility of each State. It is extremely important that each State have the flexibility to address the technology, organization, and location aspects for its specific implementation.

A.3 Technical Architecture Components

Table A-3 summarizes the components of the Technical Architecture. The TA describes the technology enablers that are associated with different levels of business process and business capability maturity. In the BPM, each business process is defined at a high level along with data input, data output, and shared data required. The business capability description for each business process also defines conceptually how data will be transformed to achieve higher levels of maturity.

Table A-3 Summary of the Technical Architecture Components

Component	Description	Role in the IA
MITA Framework 2.0 Part III Chapter 2 — MITA Principles, Goals, Objectives	These provide the vision and guidance for the MITA Technical Architecture. These principles, along with the MITA business goals, are used to define a set of supporting technical goals. The technical goals are further refined into a specific list of objectives.	Provide the basis and direction to all decisions related to the technical enablers of MITA.
MITA Framework 2.0 Part III Chapter 4 — Business Services	A specific type of Web service that provides enterprise-specific business functionality. Each business service represents a single business process at a single capability level. The service's interface is specified using Web Services Description Language (WSDL).	Exposes business processes and capabilities with standard interfaces to the entire Medicaid enterprise.
MITA Framework 2.0 Part III Chapter 5 — Technical Capability Matrix	A grid that shows each technical function as it may be transformed over time due to changes in business requirements or in technology.	Each technical capability at each level is traceable to either the Business Capability Matrix or the technical principles, goals, and objectives.
MITA Framework 2.0 Part III Chapter 6 — Technical Services	Technical Services logically define a service that provides technical functionality that enables the MITA business services to operate successfully A specific type of Web service that provides non-enterprise-specific technical functionality, these services can be thought of as system, utility, or common services. An example of this type of functionality would be a technical service that provides an authorization or encryption functionality. The service's interface is specified using Web Services Description Language (WSDL).	Technical functions and capabilities with standard interfaces to the entire enterprise.
MITA Framework 2.0 Part III Chapter 7 — Application Architecture	The **Application Architecture** defines the environment in which the services will be operating, and provides the infrastructure for orchestrating the flow of information between the appropriate technical and application processes. Some key components of the application architecture are the enterprise service bus and service management engines.	Defines the overall technical structure of an enterprise and provides the infrastructure that allows all of the components to operate successfully.
MITA Framework 2.0 Part III Chapter 8 — Technology Standards	A set of technology standards to be used in defining the various components of the technical architecture. These ensure compliance to industry standards and enable interoperability in the health care enterprise.	Aligns MITA with the other government and industry initiatives and standards.
MITA Framework 2.0 Part III Chapter 9 — Solution Sets	Provide a resource for States to determine the reusability of MITA services (business and technical) and infrastructure components. It uses standard templates to define the metadata required to describe a specific implementation of a service. Each service may have one or more solution sets based on the actual physical implementations.	Provide a resource for sharing physical implementation among States.

Figure A-4 shows the interrelationships among the TA components.

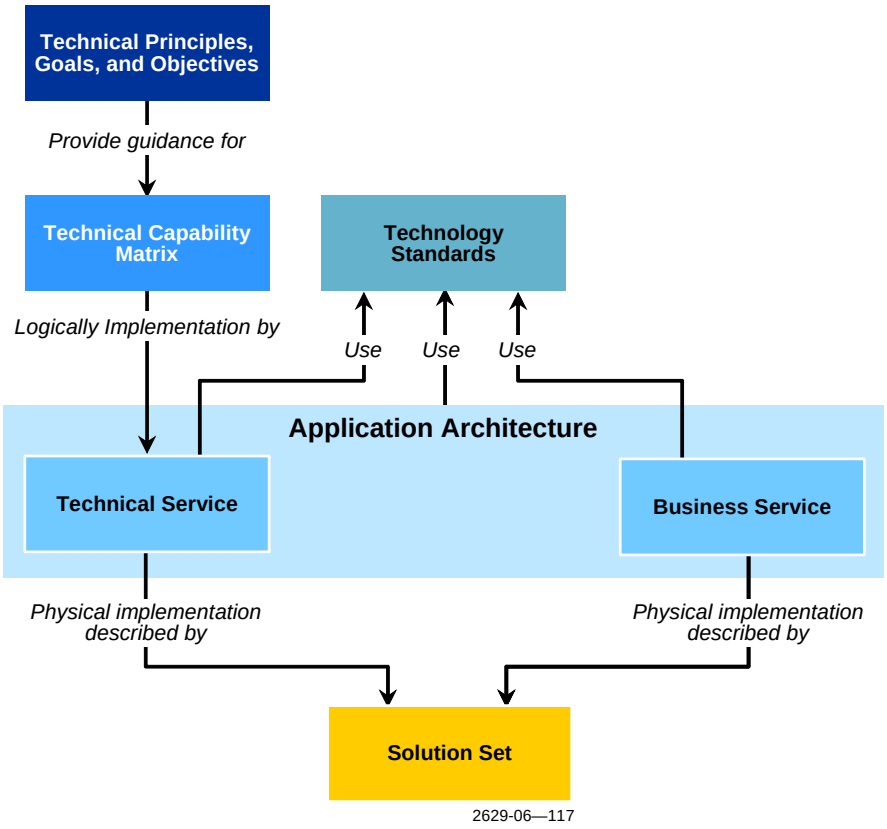


Figure A-4 TA Component Relationships

In summary, the TA components provide an integrated logical architecture that provides the standardization, interoperability, and flexibility required by the various State enterprises. The TA requires a companion IA to translate and define the information needs of the BA into the data specifications of the TA. The IA also provides the vision and guidance for information management that will be implemented in the technical functions and technical capabilities.

- BH-MITA Principles, Goals, and Objectives provide the vision and guidance for the BH-MITA Technical Architecture.
- Business Services logically define a service that provides BH functionality based on BH-MITA business processes and business capabilities.
- The Technical Capability Matrix takes the Business Capability Matrix; BH-MITA principles, goals, and objectives; and the technical functions and populates a grid to demonstrate how each area can evolve. In some cases, the technical area will be replaced by a new technical area.
- The Technical Services logically define a service that provides technical functionality that enables the BH-MITA business services to operate successfully. This functionality is

at the level of non-Medicaid-specific functionality and can be thought of as system, utility, or common services.

- The Application Architecture defines the environment in which the services will be operating. The Application Architecture also provides the infrastructure for orchestrating the flow of information between the appropriate technical and application processes.
- Solutions Sets provide a resource for States to determine the reusability of MITA services (business and technical) and infrastructure components.
- The Technical Standards are a set of standards related specifically to technology that represents MITA recommendations for State implementations. This will allow the State implementations to be compliant to industry standards and to enable interoperability of the Medicaid enterprise.

For more detail on the TA components, see the MITA Framework 2.0 at **http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp.**

Appendix B Business Process Model/Business Capability Detail

This appendix describes how to read, populate, and understand a business process table and a business capability table, as in MITA Framework Release 2.0 Part I Appendix C, (See http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp), and in Appendix B to the BH-MITA Maturity Model document. The BH-MITA BPM tables presented in this document combine elements of both a business process table and a business capability matrix, but it will be necessary for BH-MITA to eventually develop separate and fully developed business process tables and business capability matrices to progress through the Framework processes**.**

This appendix also contains a list of business processes contained in the initial BH-MITA BPM, built off of those in the MITA Framework Release 2.0, which will require a collaborative effort between States, vendors, and SAMHSA to validate as well as further identify, define and refine.

B.1 How to Read a Business Process Form

A business process is defined as a series of activities that are triggered by one or more events and lead to one or more results. All of the business processes contained in the BPM are described in a standard template that captures the Trigger, Result, and Business Logic. A Trigger event activates a business process, which is carried out in one or more steps, and produces one or more results or outcomes. Business processes are often a consolidation of several similar processes. For example, *Intake Client* is presented as a single process accommodating any kind of client. This is because the processing steps are similar for all clients even though the specific data requirements and business rules may differ depending on the provider, the state, and the client's situation and needs. This consolidation allows the BPM to remain at a manageable size.

The processes that manage incoming and outgoing transactions from any media, apply privacy and security rules, log and perform initial edits, and translate or prepare data for subsequent processing are *not* included in the BPM. They belong to a special category of business and technical services not addressed in this BH-MITA project.

The following Table B-1 shows the format of a full business process form. The Title and Tier number of the business process link it to the Business Areas shown in the next Appendix, Appendix C. Each of the sections of the business process form is described under the Details column in the table.

Table B-1 Business Process Form and Contents

Title of Business Process

Tier 3: Title of Business Process		
Item	**Details**	**Links**
Description	Overview of the business process	Connects this business process to others
Trigger Event	The action or scheduled time that initiates the process; identifies the Trigger data set. When the Conceptual Data Model is available, the Trigger data groupings should be inserted in this section.	
Result	The output(s) of the process; identifies the Result data set. When the Conceptual Data Model is available, the Result data groupings should be inserted in this section	
Business Process Steps	Enumeration of the major steps	
Shared Data	Identifies external data needed to perform the processing steps. When the Conceptual Data Model is available, the Shared data groupings should be inserted in this section	
Predecessor	Preceding business processes; i.e., the Result of a Previous business process can be the Trigger for the next one	
Successor	A business process that receives input from the result of another business process	
Constraints	States may have different approaches to the business process that need to be recognized	
Failures	Rules that specify when a business process must terminate prematurely	
Performance Measures	Type of measurement that can be used to determine the performance of this business process. The form only shows they *type* of measure to consider. Actual measures are needed in the business capabilities associated with the business process. In some of the business processes, examples of measures are supplied	

The table below lists the BH business areas and corresponding business processes identified as a start point for further collaborative State/SAMHSA development. There are 78 business processes in the BPM at this time.

Table B-2 Initial List of BH-MITA Business Processes

(Processes in ***bold and italics*** are new processes specific to BH operations)

Business Area	Business Process
Client Management (CL)	CL Manage Client/Applicant Communication
	CL Manage Client Grievance and Appeal
	CL Manage Client Information
	CL Inquire Client Information
	CL Perform Population/Client Outreach
Provider/Contractor Management (P/CM)	P/CM Close out Provider/Contractor Contracts
	P/CM Award Provider/Contractor Contract
	P/CM Register Providers/Contractors
	P/CM Inquire Provider/Contractor Information
	P/CM Manage Provider/Contractor Contracts
	P/CM Manage Provider/Contractor Communication
	P/CM Manage Provider/Contractor Grievance and Appeal
	P/CM Manage Provider/Contractor Information
	P/CM Perform Provider/Contractor Outreach and Training
	P/CM Perform Provider/Contractor Audits
Operations Management (OM)	OM Authorize Referral
	OM Authorize Service/Level of Service
	OM Apply Claim Attachment
	OM Apply Mass Adjustment
	OM Edit Claims-Encounter
	OM Price Claim - Value Encounter
	OM Prepare COB
	OM Prepare Premium EFT-check
	OM Prepare Provider EFT-check
	OM Prepare Remittance Advice-Encounter Report
	OM Prepare Grants/Cost Based Payment/Invoice
	OM Prepare Capitation Premium Payment
	OM Prepare Health Insurance Premium Payment
	OM Prepare Medicare Premium Payment
	OM Inquire Payment Status
	OM Manage Payment Information
	OM Calculate Spend-Down Amount
	OM Develop Sliding Scale
	OM Determine Client Contribution
	OM Prepare Client Invoice
	OM Collect Client Fees
	OM Manage Drug Rebate
	OM Manage Estate Recovery
	OM Manage Recoupment

Business Area	Business Process
	OM Manage Settlement
	OM Manage TPL Recovery
Program Management (PM)	PM Develop Agency Goals and Initiatives
	PM Develop and Maintain Program Policy
	PM Formulate Budget
	PM Manage Federal Funds
	PM Manage Block Grants
	PM Identify Services Provided through Block Grants
	PM Monitor Block Grant requirements
	PM Manage State Funds
	PM Manage 1099s
	PM Perform A-133 Provider Audits
	PM Generate Financial and Program Analysis Reports
	PM Manage Program Information
	PM Respond to Consent Decrees
Business Relationship Management (BR)	BR Create Business Relationship
	BR Manage Business Relationship
	BR Manage Business Relationship Communications
	BR Create Communications Protocols
	BR Create Block Grant Applications
	BR Engage in Joint Planning
	BR Terminate Business Relationship
Accountability Management (AM)	AM Initiate Case
	AM Manage Case
	AM Manage Disallowances
	AM Perform Block Grant Reviews
	AM Conduct Routine Fiscal and Clinical Monitoring
	AM Develop and Manage Performance Measures and Reporting
	AM Monitor Performance and Business Activity
	AM Initiate Accreditation Process
Care Management (CM)	CL Intake Client
	CL Screening and Assessment
	CL Manage Wait List
	CL Referral/Placement
	CL Admit/Enroll Client
	CM Coordinate/Manage Case
	CM Manage and Monitor Client and Treatment Outcomes
	CL Discharge Client
	CM Develop Treatment Plan Goals, Methods, and Outcomes
	CM Develop Discharge Planning and Aftercare Plan
	CM Prevention

B.2 How to Read the BCM Form

The Business Capability Matrix (BCM) describes the boundaries and behavior of each BH-MITA business process in the context of the five levels of the BH-MITA Maturity Model (BH-MITA MM). Appendix B in the BH-MITA Maturity Model document contains the companion Business Capabilities Matrix document that describes the process for developing the business capability levels. It is intended that every business process have its set of corresponding business capabilities. Business processes are meant to be used in conjunction with the business capabilities.

Table B-3 Business Capability 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 BPM. The high-level view of the BPM/BCM is shown in the figure below.

Table B-4 Initial List of BH-MITA Business Capabilities

Business Area	Business Process	Business Capability
Client Management (CL)	CL Manage Client/Applicant Communication	CL Manage Client/Applicant Communication
	CL Manage Client Grievance and Appeal	CL Manage Client Grievance and Appeal
	CL Manage Client Information	CL Manage Client Information
	CL Inquire Client Information	CL Inquire Client Information
	CL Perform Population/Client Outreach	CL Perform Population/Client Outreach
Provider/Contractor Management (P/CM)	P/CM Close out Provider/Contractor Contracts	P/CM Close out Provider/Contractor Contracts
	P/CM Award Provider/Contractor Contract	P/CM Award Provider/Contractor Contract
	P/CM Register Providers/Contractors	P/CM Register Providers/Contractors
	P/CM Inquire Provider/Contractor Information	P/CM Inquire Provider/Contractor Information
	P/CM Manage Provider/Contractor Contracts	P/CM Manage Provider/Contractor Contracts
	P/CM Manage Provider/Contractor Communication	P/CM Manage Provider/Contractor Communication
	P/CM Manage Provider/Contractor Grievance and Appeal	P/CM Manage Provider/Contractor Grievance and Appeal
	P/CM Manage Provider/Contractor Information	P/CM Manage Provider/Contractor Information
	P/CM Perform Provider/Contractor Outreach and Training	P/CM Perform Provider/Contractor Outreach and Training
	P/CM Perform Provider/Contractor Audits	P/CM Perform Provider/Contractor Audits
Operations Management (OM)	OM Authorize Referral	OM Authorize Referral
	OM Authorize Service/Level of Service	OM Authorize Service/Level of Service
	OM Apply Claim Attachment	OM Apply Claim Attachment
	OM Apply Mass Adjustment	OM Apply Mass Adjustment
	OM Edit Claims-Encounter	OM Edit Claims-Encounter
	OM Price Claim - Value Encounter	OM Price Claim - Value Encounter
	OM Prepare COB	OM Prepare COB
	OM Prepare Premium EFT-check	OM Prepare Premium EFT-check
	OM Prepare Provider EFT-check	OM Prepare Provider EFT-check
	OM Prepare Remittance Advice-Encounter Report	OM Prepare Remittance Advice-Encounter Report
	OM Prepare Grants/Cost Based Payment/Invoice	OM Prepare Grants/Cost Based Payment/Invoice

Business Area	Business Process	Business Capability
	OM Prepare Capitation Premium Payment	OM Prepare Capitation Premium Payment
	OM Prepare Health Insurance Premium Payment	OM Prepare Health Insurance Premium Payment
	OM Prepare Medicare Premium Payment	OM Prepare Medicare Premium Payment
	OM Inquire Payment Status	OM Inquire Payment Status
	OM Manage Payment Information	OM Manage Payment Information
	OM Calculate Spend-Down Amount	OM Calculate Spend-Down Amount
	OM Develop Sliding Scale	OM Develop Sliding Scale
	OM Determine Client Contribution	OM Determine Client Contribution
	OM Prepare Client Invoice	OM Prepare Client Invoice
	OM Collect Client Fees	OM Collect Client Fees
	OM Manage Drug Rebate	OM Manage Drug Rebate
	OM Manage Estate Recovery	OM Manage Estate Recovery
	OM Manage Recoupment	OM Manage Recoupment
	OM Manage Settlement	OM Manage Settlement
	OM Manage TPL Recovery	OM Manage TPL Recovery
Program Management (PM)	PM Develop Agency Goals and Initiatives	PM Develop Agency Goals and Initiatives
	PM Develop and Maintain Program Policy	PM Develop and Maintain Program Policy
	PM Formulate Budget	PM Formulate Budget
	PM Manage Federal Funds	PM Manage Federal Funds
	PM Manage Block Grants	PM Manage Block Grants
	PM Identify Services Provided through Block Grants	PM Identify Services Provided through Block Grants
	PM Monitor Block Grant requirements	PM Monitor Block Grant requirements
	PM Manage State Funds	PM Manage State Funds
	PM Manage 1099s	PM Manage 1099s
	PM Perform A-133 Provider Audits	PM Perform A-133 Provider Audits
	PM Generate Financial and Program Analysis Reports	PM Generate Financial and Program Analysis Reports
	PM Manage Program Information	PM Manage Program Information
	PM Respond to Consent Decrees	PM Respond to Consent Decrees
Business Relationship Management (BR)	BR Create Business Relationship	BR Create Business Relationship

Business Area	Business Process	Business Capability
	BR Manage Business Relationship	BR Manage Business Relationship
	BR Manage Business Relationship Communications	BR Manage Business Relationship Communications
	BR Create Communications Protocols	BR Create Communications Protocols
	BR Create Block Grant Applications	BR Create Block Grant Applications
	BR Engage in Joint Planning	BR Engage in Joint Planning
	BR Terminate Business Relationship	BR Terminate Business Relationship
Accountability Management (AM)	AM Initiate Case	AM Initiate Case
	AM Manage Case	AM Manage Case
	AM Manage Disallowances	AM Manage Disallowances
	AM Perform Block Grant Reviews	AM Perform Block Grant Reviews
	AM Conduct Routine Fiscal and Clinical Monitoring	AM Conduct Routine Fiscal and Clinical Monitoring
	AM Develop and Manage Performance Measures and Reporting	AM Develop and Manage Performance Measures and Reporting
	AM Monitor Performance and Business Activity	AM Monitor Performance and Business Activity
	AM Initiate Accreditation Process	AM Initiate Accreditation Process
Care Management (CM)	CL Intake Client	CL Intake Client
	CL Screening and Assessment	CL Screening and Assessment
	CL Manage Wait List	CL Manage Wait List
	CL Referral/Placement	CL Referral/Placement
	CL Admit/Enroll Client	CL Admit/Enroll Client
	CM Coordinate/Manage Case	CM Coordinate/Manage Case
	CM Manage and Monitor Client and Treatment Outcomes	CM Manage and Monitor Client and Treatment Outcomes
	CL Discharge Client	CL Discharge Client
	CM Develop Treatment Plan Goals, Methods, and Outcomes	CM Develop Treatment Plan Goals, Methods, and Outcomes
	CM Develop Discharge Planning and Aftercare Plan	CM Develop Discharge Planning and Aftercare Plan
	CM Prevention	CM Prevention

Appendix C BH-MITA Business Process Model

This document includes a simplified version of a BPM that is intended to assist states in developing a detailed, BH specific model. The BH-MITA BPM tables provide a foundation for replicating the MITA BPM development process, using intensive state involvement over time to flesh out the universe of processes, elements and detail for a complete picture of current BH business operations. The BH-MITA BPM builds off of the BPM in MITA Framework Release 2.0 Part I Appendix C, at http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp, and incorporates some information in the recently released MITA BPM 2.01, found at the HL7 MITA Project site at http://hl7projects.hl7.nscee.edu/docman/?group_id=40. It also uses the input gathered in October 2007 from a select group of representatives from Federal agencies, Federal BH contractors, and national BH agency associations exploring how the MITA BPM could be adapted for BH agencies.

The simplified BH-MITA BPM provided here includes elements of both a MITA BPM and a business capability matrix (BCM) as described below:

- A high-level description of a business activity (a series of steps)
- A general description of the shared data that the activity uses
- A series of five maturity levels highlighting key elements of change in the associated business capabilities

This format was chosen as a way to provide the states with some direction for developing a separate and complete BPM and BCM, which are both necessary for progressing to the next steps in the framework. The business capability levels describe key indicators of technological and operational progress over time as agencies move their business operations and technologies towards the future vision. Key attributes that are developed and integrated over time at each level are quality edits, adopting standards, cross program collaboration/one stop shopping, access to clinical information electronically, and nationwide electronic exchange of information. A sample table is replicated below in Table C-1.

Table C-1 Sample Business Relationship Management Table

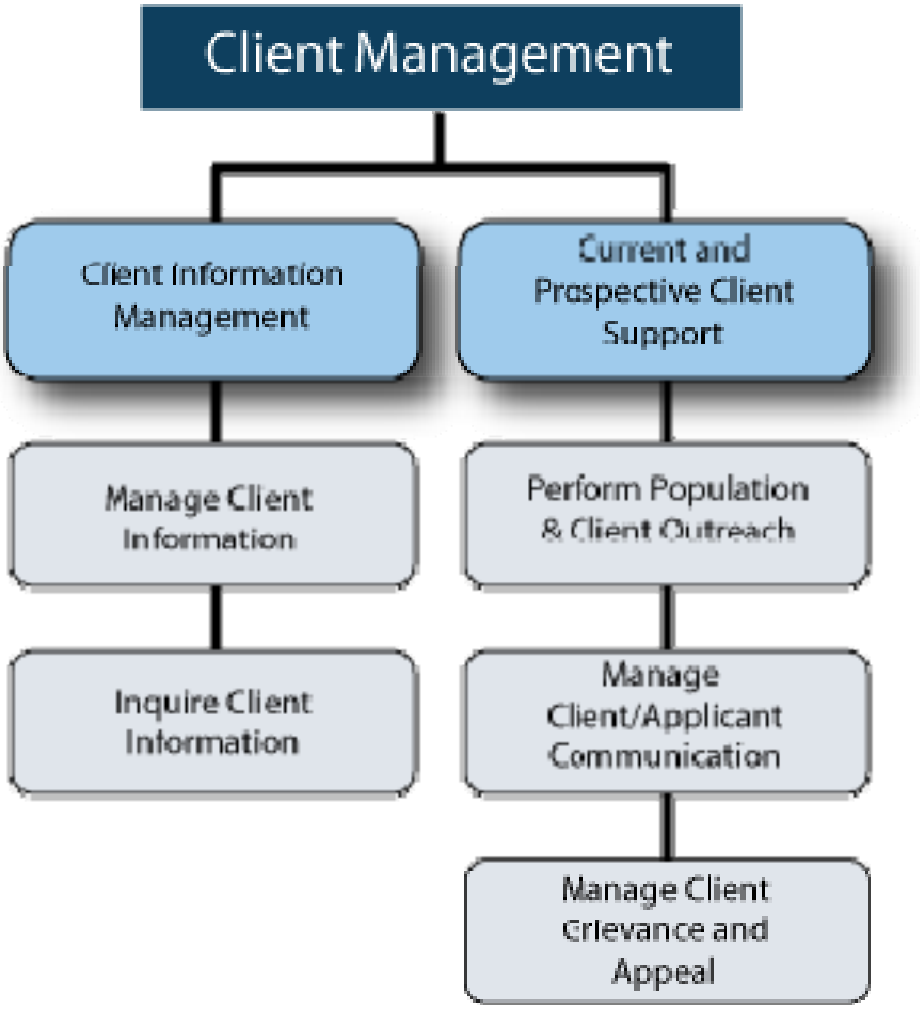
Business Relationship Management (BRM)

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

Note that the BH-MITA BPM in this document is NOT equivalent to the MITA 2.0 BPM; this BPM only provides a start point for BH agencies to create a comprehensive description of the business processes involved in BH operations today. This BH-MITA BPM provides a "straw man" model intended to facilitate BH agencies' development of a full fledged, comprehensive BH BPM. This will require further work by and ongoing involvement of both SAMHSA and state BH agencies to achieve the next level of business process description and completeness as reached in the BPM in the MITA Framework 2.0.

The business process tables associated with each business area that make up the BH-MITA BPM are detailed below.

Client Management (CL)



Client Management (CL)

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

Client Management (CL)

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

Client Management (CL)

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

CL: Manage Client Information: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The business process is primarily designed to serve State BH programs and meet Federal reporting requirements. The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Data is usually shared on a scheduled or ad hoc basis. This Level complies with agency requirements.	The business process is extended by "work-arounds" to meet the needs of providers and other programs. The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. Cases are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to client administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Client information is accessible to any authorized party through HIEs statewide. Pointers to selected clinical information link it to other client and provider/contractor data to allow ongoing monitoring and quality control. Client specific clinical data is accessible electronically. This Level adds clinical data.	Client information is federated with HIEs nationally so that any stakeholder can access or request client administrative and clinical information to the extent authorized anywhere in the country. This Level adds nationwide technical interoperability.

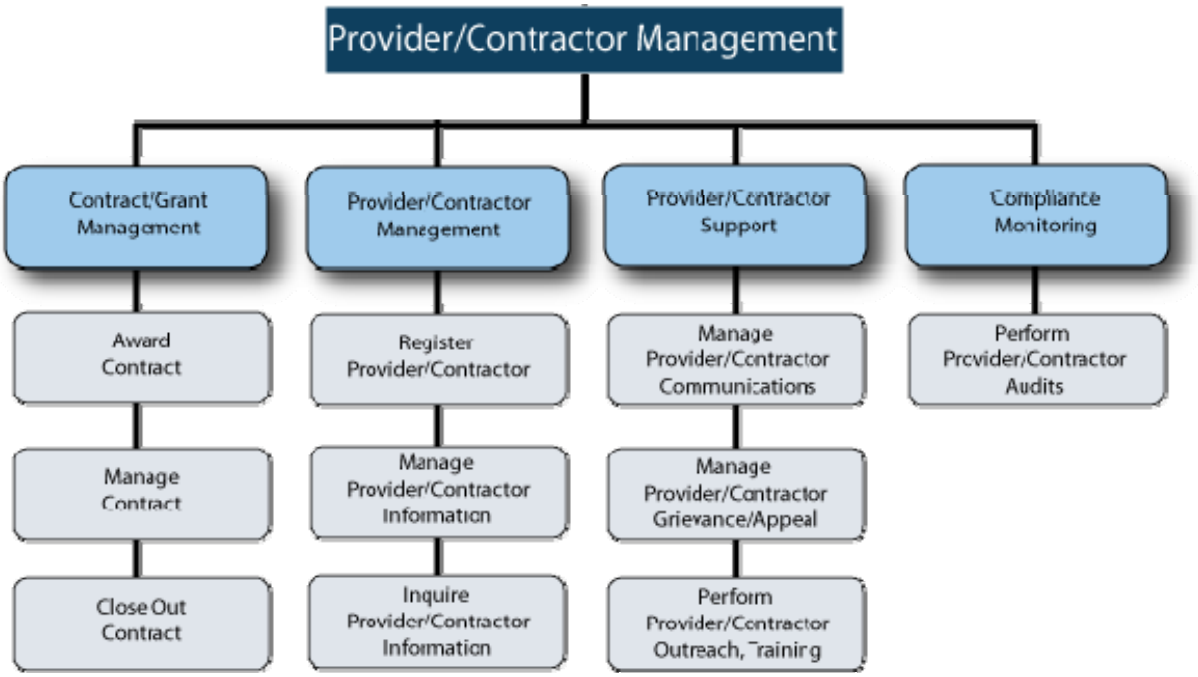
Client Management (CL)

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

Client Management (CL)

CL: Perform Population/Client Outreach Process					
Item	**Details**				
Description	The ***Perform Population and Client Outreach*** business process originates internally within the Agency to identify and notify prospective and current clients about BH programs and services; create and provide linguistically and culturally appropriate information and educational materials to those same clients; and monitor outreach efforts and effectiveness. Client data is analyzed to develop outreach methods and materials and to target specific populations. **NOTE:** The ***Perform Population and Client Outreach*** process targets both prospective and current client *populations*. The ***Manage Client/Applicant Communication*** process provides assistance and responses to *individuals*.				
MITA Reference	Source Process Name: *Perform Population and Member Outreach* Source Process Business Area: *Member Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Population health data Accountability and quality measure data Service data: Services and provider types; program policy; and provider/ contractor information	Client demographics and service history Client social, functional, clinical, and financial data Provider/contractor data, such as type, location, language, availability.			
CL: Perform Population/Client Outreach: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
Outreach and education materials are manually prepared and updated. Agencies use TV, radio, and newspaper advertisements to distribute materials and messages. Outreach across multiple, siloed programs is uncoordinated, and linguistic and cultural sensitivity is lacking. Quality and consistency of outreach and education efforts is variable. This Level complies with agency requirements.	Increased use of agency standards for client data improves identification of gaps in client outreach. Agencies add Websites, TV, radio and other media to their outreach methods and can distribute electronic outreach information and messages where viable. Standard outreach information is maintained and available to clients via a Web portal. This Level includes additional data and quality edits	At this level, current and prospective client s can access outreach information available via state Web portals from any service location. Outreach is coordinated with other state agencies using BH-MITA and MITA standard data and interfaces. Automated translation and repositories of cultural and competency appropriate statements facilitates material development. At this Level data is standardized against HL7 RIM.	Client outreach is coordinated regionally, multi-agency in scope, and facilitated through HIEs statewide. Clinical and administrative information can automatically trigger outreach and educational material to be sent to the client and/or the provider/ contractor. Outreach materials are automatically generated and sent in response to electronic requests. This Level adds clinical data.	The business process is national in scope, based on analysis of clinical, demographic, and socio-economic indicators and shared among other BH agencies and public programs. Client outreach is facilitated through HIEs nationally. Nationwide collaborations streamline outreach and education to clients anywhere in the country. This Level adds nationwide technical interoperability.	

Provider/Contractor Management (P/CM)



Provider/Contractor Management (P/CM)

P/CM: Close out Provider/Contractor Contracts Process				
Item	**Details**			
Description	The ***Close-out Provider/Contractor Contract*** business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new provider/contractor is completed according to contractual obligations. This process is also used if the contract must be terminated for reasons other than reaching contract expiration.			
MITA Reference	Source Process Name: *Close Out Health Services Contract* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Provider/Contractor name Provider/Contractor address Provider/Contractor ID	Provider/Contractor type Provider/Contractor contract specs Provider/Contractor funding amount		
P/CM: Close out Provider/Contractor Contracts: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Communications and information exchange for this business process is primarily via paper, telephone, & fax. The process is inconsistent in the application of the rules and in response timing, and uses multiple data formats and semantics. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces for trading partner agreements; basic business rules; and enhanced consistency of responses and timing. Cases are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and use of some clinical data to improve monitoring. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is conducted using virtual records and processes through HIEs statewide. Clinical data, when necessary, is accessible by direct access. Contracting processes become standardized across agencies and programs. This Level adds clinical data.	The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual clinical record and administrative data access. The process accesses national guidelines and best practices. This Level adds nationwide technical interoperability.

Provider/Contractor Management (P/CM)

P/CM: Award Provider/Contractor Contracts Process					
Item	**Details**				
Description	The ***Award Provider/Contractor Contract*** business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.				
MITA Reference	Source Process Name: *Award Health Services Contract* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Provider/Contractor name Provider/Contractor address Provider/Contractor ID	Provider/Contractor type Provider/Contractor contract specs Provider/Contractor funding amount			
P/CM: Award Provider/Contractor Contracts: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
Communications and information exchange for this business process is primarily via paper, telephone, & fax, using non-standard formats for proposals and data. The process is inconsistent in the application of the rules and in response timing. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces for trading partner agreements; basic business rules; and enhanced consistency of responses and timing. Proposal formats and data are standardized within the state. Cases are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and use of some clinical data to improve monitoring. Proposal formats and data are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process uses virtual records and a broad spectrum of clinical data for tracking outcomes. Clinical data, when necessary, is accessible by direct access. Contracting processes become standardized across agencies and programs. This Level adds clinical data.	The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual clinical record and administrative data access. The process accesses national guidelines and best practices. This Level adds nationwide technical interoperability.	

Provider/Contractor Management (P/CM)

P/CM: Register Provider/Contractors Process					
Item	**Details**				
Description	The ***Register Provider/Contractor*** business process is responsible for managing provider/contractor certification to offer BH programs and services, including • Receipt of certification application data • Processing of applications, including status tracking and validating application meets state submission rules, e.g., syntax/semantic conformance • Validation that the registration meets state/federal requirements by performing primary source verification of credentials and sanction status				
MITA Reference	Source Process Name: *Enroll Provider* Source Process Business Area: *Provider Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Provider/Contractor data: e.g., provider/contractor demographics, provider/contractor taxonomy Provider/Contractor ID, NPI	Multiple office locations, pay to addresses, business associates and key contract personnel Tax identifiers			
P/CM: Register Provider/Contractors: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
This business process is primarily conducted via paper using non-standard forms and data. Staff process paper registrations and manually apply the agency's business rules and other requirements to maximize access to a range of services. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces for registrations and verification sources; basic business rules; and state agency specific standards. Registration is timely, accurate and supports an optimal service mix. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and use of some clinical data to improve monitoring. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process has automated access to virtual records and a broad spectrum of clinical data for tracking outcomes. Clinical information is considered in validating credentials and identifying service offerings. This Level adds clinical data.	All registration processes are automated using point-to-point collaboration, full interoperability with other local, state, and federal programs, and access to all provider/contractor registries nationally. The process accesses national guidelines and best practices. This Level adds nationwide technical interoperability.	

Provider/Contractor Management (P/CM)

P/CM: Inquire Provider/Contractor Information Process	
Item	**Details**
Description	The ***Inquire Provider/Contractor Information*** business process receives requests for provider/contractor information from authorized providers/contractors, programs or business associates; performs the inquiry; and prepares the response data set.
MITA Reference	Source Process Name: *Inquire Provider Information; Inquire Contractor Information* Source Process Business Area: *Provider Management; Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp
Sample Data	Provider/contractor databases

P/CM: Inquire Provider/Contractor Information: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces for inquiries; basic business rules; and state agency specific standards. Routine inquiries for provider/contractor information are standardized and automated within the agency. This Level includes additional data and quality edits.	The process has virtual access to provider/contractor data. Cross agency collaboration results in a one-stop shop, with information accessible to external partners and clients via the Web. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Provider/contractor information is accessible to any authorized party through HIEs statewide. Pointers to selected clinical information link it to provider/contractor data. For example, a provider can inquire about summary clinical records of hospitals, labs, or specialists before making a referral. This Level adds clinical data.	Provider/contractor information is federated with HIEs nationally so that any stakeholder can request provider/contractor information to the extent authorized anywhere in the country. This Level adds nationwide technical interoperability.

Provider/Contractor Management (P/CM)

P/CM: Manage Provider/Contractor Contracts Process					
Item	**Details**				
Description	The ***Manage Provider/Contractor Contracts*** business process maintains the agreement between the State BH agency and the other party. This includes routine changes to required information such as authorized signers, addresses, coverage, and data exchange standards.				
MITA Reference	Source Process Name: *Manage Health Services Contracting* Source Process Business Area: *Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Standard agreement template Business rules for type of agreement	Data from previous agreement for same party			
P/CM: Manage Provider/Contractor Contracts: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Contract formats and data are standardized within the state. Inquiries are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses clinical data to improve monitoring. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Provider/contractor information is accessible to any authorized party through HIEs statewide. Pointers to selected clinical information link it to provider/contractor data to allow ongoing monitoring and quality control. Additional business partner data are available for use in this process. This Level adds clinical data.	The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual clinical record and administrative data access. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. This Level adds nationwide technical interoperability.	

Provider/Contractor Management (P/CM)

P/CM: Manage Provider/Contractor Communications Process					
Item	**Details**				
Description	The ***Manage Provider/Contractor Communication*** business process receives requests for information, provider/contractor publications, and assistance from prospective and current providers/contractors' communications such as inquiries related to registration, services, funding/reimbursement, reporting requirements, etc. Communications are researched, developed and produced for distribution. Note: The ***Manage Provider/Contractor Communication*** process provides assistance and responses to *individual entities*. The ***Perform Provider/Contractor Outreach*** process targets communications to both prospective and current provider/contractor *populations*.				
MITA Reference	Source Process Name: *Manage Provider Communication; Manage Contractor Communication* Source Process Business Area: *Provider Management; Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Service data: Services and provider types; program policy; and provider/ contractor information	Provider/contractor data, such as type, location, language, availability.			
P/CM: Manage Provider/Contractor Communications: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. Communication is not coordinated among multiple, siloed programs and not systematically triggered by agency-wide processes. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Routine communications with providers/ contractors are standardized and automated within the agency. This Level includes additional data and quality edits.	The process operates through virtual access to providers/ contractors. Communications are standardized within the agency and coordination cross agency results in improved efficiencies. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Provider/contractor communications are handled through HIEs statewide, and regular communications are automatic. All health care agencies collaborate in communications between agencies and among all providers/ contractors statewide. This Level adds clinical data.	Provider/contractor communications are handled through HIEs nationally. Nationwide collaborations streamline communications with providers/ contractors anywhere in the country. This Level adds nationwide technical interoperability.	

Provider/Contractor Management (P/CM)

P/CM: Manage Provider/Contractor Grievance and Appeal Process					
Item	**Details**				
Description	The ***Manage Provider/Contractor Grievance and Appeal*** business process handles prospective and current provider/contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received, logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling issued. Results of the hearing and relevant documents are stored in the provider/contractor information file. **NOTE:** States may define "grievance" and "appeal" differently, depending on state laws.				
MITA Reference	Source Process Name: *Manage Provider Grievance and Appeal; Support Contractor Grievance and Appeal* Source Process Business Area: *Provider Management; Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Service data: Services and provider types; program policy; and provider/ contractor information	Provider/contractor data, such as type, location, language, availability. Grievance and Appeal Case Files			
P/CM: Manage Provider/Contractor Grievance and Appeal: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
This business process is primarily via USPS & fax using non-standard formats. Confidential documents are transferred by certified mail. The process is lengthy, and may have inconsistencies between cases of the same type. This Level complies with agency requirements.	The process incorporates Web interfaces for inquiries; scanned files; basic business rules; and state agency specific standards. The process Is partially automated, improving consistency and reducing review time. This Level includes additional data and quality edits.	BH-MITA standard data and MITA compatible system interfaces are used to initiate and develop the case. The case file is Web-enabled to facilitate sharing among the review team. Cross agency coordination results in a one-stop shop model for both provider/contractor and consumer appeals. At this Level data is standardized against HL7 RIM.	The process can be initiated by business partners and clients through HIEs statewide. Clinical data and automated business rules help substantiate case findings and lead to earlier resolution of cases. A case against a provider/contractor may be triggered directly from the clinical record. This Level adds clinical data.	Interoperability and data sharing agreements across states facilitate case resolution through HIEs nationally. For example, one state can view how other states have resolved similar cases; one state can determine if the provider/contractor is (or has been) involved in similar cases in other states. This Level adds nationwide technical interoperability.	

Provider/Contractor Management (P/CM)

P/CM: Manage Provider/Contractor Information Process					
Item	**Details**				
Description	The ***Manage Provider/Contractor Information*** business process manages all operational aspects of the Provider/Contractor data, the source of comprehensive information about prospective and current providers/contractors, and their interactions with the state BH agency and other state programs such as Medicaid. The database may also store records or pointers to records for services requested and services provided; performance, utilization, and audits and reviews; and participation in client care management.				
MITA Reference	Source Process Name: *Manage Provider Information; Manage Contractor Information* Source Process Business Area: *Provider Management; Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Provider/contractor demographics; business identifier, contact, and address; credentialing, enumeration, performance profiles; payment processing, and tax information	Contractual terms, such as contracted services; related performance measures, and the funding/ reimbursement rates.			
P/CM: Manage Provider/Contractor Information: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. Cases are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Provider/contractor information is accessible to any authorized party through HIEs statewide. Pointers to selected clinical information link it to provider/contractor data to allow ongoing monitoring and quality control. This Level adds clinical data.	Provider/contractor information is federated with HIEs nationally so that any stakeholder can access or request provider/contractor information to the extent authorized anywhere in the country. This Level adds nationwide technical interoperability.	

Provider/Contractor Management (P/CM)

P/CM: Perform Provider/Contractor Outreach and Training Process		
Item	**Details**	
Description	The ***Perform Provider/Contractor Outreach and Training*** business process responds to training needs such as changes in funding/reimbursement rules, program announcements, and policy clarifications. For prospective providers/contractors, develop outreach information on rules of participation, registration directions and funds application, and benefits of participation.	
MITA Reference	Source Process Name: *Perform Provider Outreach; Perform Potential Contractor Outreach* Source Process Business Area: *Provider Management; Contractor Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Population health data Accountability and quality measure data Service data: Services and provider types; program policy; and provider/ contractor information	Client demographics Client social, functional, clinical, and financial data Provider/contractor data, such as type, location, language, availability.

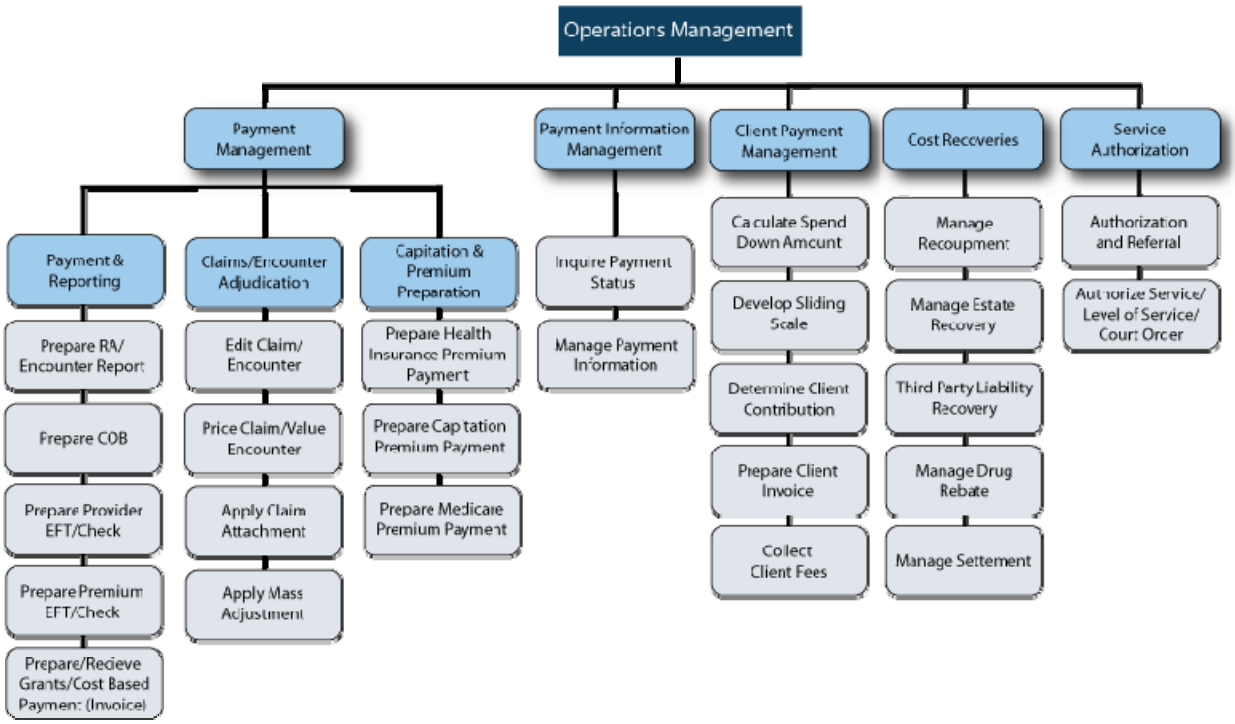
P/CM: Perform Provider/Contractor Outreach and Training: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Outreach and education materials are manually prepared and updated. Agencies use TV, radio, and newspaper advertisements to distribute materials. Outreach across multiple, siloed programs is uncoordinated, and linguistic and cultural sensitivity is lacking. Quality and consistency of outreach and education efforts is variable. This Level complies with agency requirements.	Increased use of agency standards for provider/ contractor data improves identification of provider/contractor gaps in services, location, cultural and linguistic needs. Linguistically, culturally, and competency appropriate material requires significant manual intervention. Electronic materials are available via a Web portal. Standard educational/policy information is maintained and distributed via electronic media. This Level includes additional data and quality edits.	Outreach and education materials are available via state Web portals using BH-MITA and MITA standard data and interfaces and are shared with other collaborating agencies. Automated translation and repositories of cultural and competency appropriate statements facilitates material development. Training courses are available online, and completion is documented. At this Level data is standardized against HL7 RIM.	Provider/contractor communications, training, and outreach are handled through HIEs statewide; regular training and outreach contacts are automatic. All health care agencies collaborate in communications, training, and outreach to providers/ contractors statewide. Clinical and administrative information can automatically trigger outreach and educational material to be sent to the provider/ contractor. This Level adds clinical data.	Provider/contractor communications, training, and outreach are handled through HIEs nationally; states can share provider/contractor outreach and education materials through HIEs as well. Nationwide collaborations streamline communications with and outreach and education to providers/ contractors anywhere in the country. This Level adds nationwide technical interoperability.

Provider/Contractor Management (P/CM)

P/CM: Perform Provider/Contractor Audits Process		
Item	**Details**	
Description	The ***Perform Provider/Contractor Audits*** process utilizes the mechanisms and measures developed by and used in the ***Accountability Management*** business area. The process includes the steps involved in implementing the mechanisms and measures to track provider/contractor activity, effectiveness, and other characteristics as required for state and federal contracts and for fiscal and other monitoring requirements.	
MITA Reference	Source Process Name: *Monitor Performance and Business Activity (incomplete)* Source Process Business Area: *Program Integrity Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Potentially, all agency data Measurement rules Billing and invoicing data and records	Progress notes Provider/contractor documentation Client records

P/CM: Perform Provider/Contractor Audits: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Audits are performed manually, often through agency team visits to provider/ contractor sites. Audits require review and copying of paper client and other records; audit analysis is manual and resource intensive. Providers/ contractors may be audited multiple times by different state agencies or for different agency programs. This Level complies with agency requirements.	Audits are still performed manually through onsite visits, but the process uses Web interfaces; scanned files; basic business rules; and state agency specific standards. Analysis is increasingly aided by automated tools, improving consistency and reducing review time. This Level includes additional data and quality edits.	Audits are primarily performed through onsite visits, but data is captured in advance of the visit, reducing onsite time. Improved audit analysis tools and Web-enabled case files facilitate review and reduce process time. Agencies have largely consolidated their audits processes and coordinated visits to minimize service disruptions. BH-MITA standard data and MITA compatible system interfaces are used to initiate and perform the review process. At this Level data is standardized against HL7 RIM.	Audits use a combination of manual and electronic processes, reducing visit frequency but allowing more electronic auditing of certain activities. The availability of clinical data and built in analysis tools shortens audit cycles by allowing some tasks to be conducted remotely. Audits may be triggered directly from information in clinical or administrative records. This Level adds clinical data.	Interoperability and data sharing agreements across states facilitate audits through HIEs nationally. Audits are ongoing, using automated audit tools and monitoring of clinical and administrative data with minimal human intervention. All state and federal audits are fully integrated. This Level adds nationwide technical interoperability.

Operations Management



Operations Management (OM)

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

Operations Management (OM)

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

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

Operations Management (OM)

OM: Apply Claim Attachment		
Item	**Details**	
Description	This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) from the ***Edit Claim/Encounter*** or ***Audit Claim/Encounter*** process or has been sent by the provider/contractor unsolicited, linking it with a trace number to associated claim, validating application level edits, determining if the data set provides all information necessary to adjudicate the claim.	
MITA Reference	Source Process Name: *Apply Claim Attachment* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Transaction Repository Provider/Contractor data	Client data Service/reference file

OM: Apply Claim Attachment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper; paper claim attachments are sent separately from the claim using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. Not all agencies use claim or attachment equivalents for reimbursement. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Claims are aligned to the HIPAA standards, X12 835 and 837. Attachments are aligned to the HIPAA standard, X12 275. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Attachments are no longer required with direct access to the clinical data stored in HIEs statewide. This Level adds clinical data.	Accessible clinical data available through HIEs nationwide eliminates the need for attachments. This Level adds nationwide technical interoperability.

Operations Management (OM)

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

Operations Management (OM)

OM: Edit Claims-Encounter		
Item	**Details**	
Description	The ***Edit Claim/Encounter*** business process receives an original or an adjustment claim/encounter data set and determines its submission status, and validates edits, service coverage and coding. The process sends validated data sets to ***Audit Claim/Encounter*** process and data sets that fail audit to the ***Prepare Remittance Advice/Encounter Report*** process.	
MITA Reference	Source Process Name: *Edit Claims-Encounter* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Provider/contractor data Client data: e.g., treatment and progress status data for checking service appropriateness Reference file	Service data: e.g., units and funding limits for services Payment history: ICN, date of service, service, diagnosis codes

OM: Edit Claims-Encounter: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency receives paper claims and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Paper transactions are batched and scanned (or data entered). Data is not comparable across agency and program silos. Not all agencies use claim equivalents for reimbursement. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Claims are aligned to the HIPAA standards, X12 275 and 837. Translators convert national data standards to state-specific data to support business processes. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Claims edits are minimized with direct access to the clinical and administrative data stored in HIEs statewide. Claim edits are automated using direct access to clinical and administrative data in HIEs. This Level adds clinical data.	Accessible clinical and administrative data available through HIEs nationwide reduces the need for claim edits and allows for complete automation of the edit process. This Level adds nationwide technical interoperability.

Operations Management (OM)

OM: Price Claim Value Encounter		
Item	**Details**	
Description	The ***Price Claim/Value Encounter*** business process begins with receiving a claim/encounter data set from the ***Audit Claim/Encounter*** process, applies pricing algorithms, calculates premiums, calculates and applies provider/contractor advances, and deducts recoupments. This process is also responsible for ensuring that all adjudication events are documented in the Payment History and are accessible to all Business Areas. **NOTE:** An adjustment to a claim follows generally the same process path.	
MITA Reference	Source Process Name: *Price Claim/Value Encounter* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Provider/contractor data Client data: e.g., treatment and progress status data for checking service appropriateness	Service data: e.g., units and funding limits for services Reference file

OM: Price Claim Value Encounter: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Selected standard services are automatically priced using rate, fee, and contract reference data. Atypical provider/contractor and other services are manually priced. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. Not all agencies use claim equivalents for reimbursement. This Level complies with agency requirements.	More services are automatically priced and there are fewer pricing exceptions. Most single claim adjustments are automated. Pricing formulas are agency-specific. Claims are aligned to the HIPAA standards, X12 275 and 837. Translators convert national data standards to state-specific data to support business processes. This Level includes additional data and quality edits.	BH agency coordinates with Medicaid and other agencies to utilize a single claim adjudication and pricing process. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. Flexible business rules allow maximum flexibility in changing pricing algorithms. At this Level data is standardized against HL7 RIM.	Pricing is embedded in communications with direct access to the clinical and administrative data stored in HIEs statewide. As service data is entered into the clinical record, authorization and pricing are immediately established by the payer application. This Level adds clinical data.	The agency uses clinical and administrative data available through HIEs nationwide to automate the process, including comparing and selecting prices based on regional averages or other pricing methodologies This Level adds nationwide technical interoperability.

Operations Management (OM)

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

Operations Management (OM)

OM: Prepare Premium EFT-check		
Item	**Details**	
Description	The ***Prepare Premium EFT/Check*** business process manages the generation of electronic and paper based reimbursement instruments, including calculation of premium, application of automated or user defined adjustments based on contract, disbursement of premium, association with an X12 820 electronic premium payment transaction when necessary, routing the payment for electronic fund transfer (EFT) or check generation and mailing.	
MITA Reference	Source Process Name: *Prepare Premium EFT/Check* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Premium, stop-loss data, "pay to" instructions, routing instructions, adjustments, incentives	Provider/contractor demographics Accounting rules, rates, funding sources

OM: Prepare Premium EFT check: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The agency or Department of Finance produces the EFT transaction or a paper check using agency or state DOF standards for format and data content. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Agency encourages electronic billers to adopt EFT payment, and uses the X12 820 standard. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. All electronic billers receive EFT payment. Through inter-agency coordination, multiple agencies share the same EFT process. Interfaces use BH-MITA standards and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Payments are made directly to provider/contractor bank accounts triggered by entries into clinical records accessible through HIEs statewide. This Level adds clinical data.	EFT payments are distributed to any location in the country through HIEs nationwide. This Level adds nationwide technical interoperability.

Operations Management (OM)

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

Operations Management (OM)

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

Operations Management (OM)

OM: Prepare Grants/Cost-Based Payment/Invoice					
Item	**Details**				
Description	The ***Prepare Grants/Cost-Based Payment/Invoice*** business process is scheduled as stipulated by Trading Partner Agreement and includes retrieving and converting transaction data. The process includes receiving provider/contractor invoices, retrieving provider/contractor and service data, retrieving the contracted/cost-based rate data associated with the services, formatting the results into required output data set, and producing invoices to be processed through the agency payment system.				
MITA Reference	None				
Sample Data	Client data		Payment History		
OM: Prepare Grants/Cost-Based Payment/Invoice: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The agency receives and produces paper invoices and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Paper transactions are batched and scanned (or data entered). Data is not comparable across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Grants/cost-based payments are aligned to the HIPAA standards, X12 275 and 837. Translators convert national data standards to state-specific data to support business processes. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Process is terminated with full alignment with national standards.	NA	

Operations Management (OM)

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

Operations Management (OM)

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

Operations Management (OM)

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

Operations Management (OM)

OM: Inquire Payment Status		
Item	**Details**	
Description	The ***Inquire Payment Status*** business process begins with receiving a claim status inquiry via paper, phone, fax or 276 EDI transaction for the current status of a specified claim(s), calling the payment history data store and/or repository, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response, and sending claim status response data set.	
MITA Reference	Source Process Name: *Inquire Payment Status* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Claims and encounter adjudication log, edit and audit exceptions, claim attachment, and claim's disposition Claims, encounter reporting, EFT/check preparation and transmittal	Premium and capitation request processing log, exceptions, and payment data

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

Operations Management (OM)

OM: Manage Payment Information					
Item	**Details**				
Description	The ***Manage Payment Information*** business process is responsible for managing all the operational aspects of the Payment Information Repository, the source of comprehensive payment information made to and by the state BH agency for health care and support services. These processes send requests to add, delete, or change data in payment records from exchanges with other payment processes.				
MITA Reference	Source Process Name: *Manage Payment Information* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Claims and encounter adjudication log, edit and audit exceptions, claim attachment, and claim's disposition Claims, encounter reporting, EFT/check preparation and transmittal	Premium and capitation request processing log, exceptions, and payment data			
OM: Manage Payment Information: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The business process is focused primarily on meeting reporting requirements for funding. The process uses primarily paper/phone/fax based processing and some proprietary systems, using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Using payment data for analysis or outcome measures requires costly and untimely statistical manipulation. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. Inquiries are received and responded to electronically. All programs use HIPAA X12 standards for claims history records, including COB and encounter data, claims attachments, and premium payments.. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. Claims processing is real time. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Profiles of BH enterprise payment history and other BH payment information are accessible to any authorized party through HIEs and regional record locator services statewide. Real time processing makes claims data available almost immediately. Decision support and sophisticated analytic tools allow for ad hoc analysis and reporting in real time. Pointers to selected clinical information link it to payment data to allow ongoing monitoring and quality control. This Level adds clinical data.	Payment information is federated with HIEs nationally so that any stakeholder can access payment information to the extent authorized anywhere in the country. Claims are no longer sent or compiled by the Agency, and direct access eliminates redundant collection and interchange of data, and improves real-time processing. This Level adds nationwide technical interoperability.	

Operations Management (OM)

OM: Calculate Spend-Down Amount				
Item	**Details**			
Description	The ***Calculate Spend-Down Amount*** business process describes the process by which spend-down amounts are tracked and a client's responsibility is met through the submission of medical claims. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels. The ***Calculate Spend-Down Amount*** business process begins with the receipt of client eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the client is assigned to a benefit package or program that requires a predetermined amount the client must be financially responsible for prior to Medicaid payment for any medical services.			
MITA Reference	Source Process Name: *Calculate Spend-Down Amount* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Client data	Payment History Data		
OM: Calculate Spend-Down Amount: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily paper based, manually adding paper bills and receipts until the spend-down amount for each period is met. Not all agencies use claim equivalents for reimbursement. This Level complies with agency requirements.	The process is conducted electronically. Applicants submit electronic reports, and scan, fax, or mail bills and receipts. Providers/ contractors have difficulty tracking spend down and determining whether to bill, as claims are denied when the client has not yet met spent down requirements. This Level includes additional data and quality edits.	The process automatically enters a deductible amount equal to the client's spend-down requirements for the specified period and adjusts it electronically. . Agencies support transmission of spend down information on the X12 270-271. At this Level data is standardized against HL7 RIM.	Providers/ contractors enter new service information into clinical records accessible to any authorized party through HIEs statewide, which can immediately determine spend down. Spend down is essentially eliminated as a distinct business process. This Level adds clinical data.	N/A

Operations Management (OM)

OM: Develop Sliding Scale		
Item	**Details**	
Description	The ***Develop Sliding Scale*** business process begins with estimating the average client's ability to pay, usually as compared to current Federal Poverty Level data, and assigning a percentage to successive dollar ranges equivalent to client resources. Agencies may also factor in the available budget and estimated client load in setting the scale.	
MITA Reference	None	
Sample Data	Client data Agency budgets	Current Federal Poverty Level data

OM: Develop Sliding Scale: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Sliding scales are manually developed each year using available federal, state and client data. Data may be incomplete, untimely, and non-standard, making comparisons difficult. Methods for calculating the scale are simple and may differ from year to year, and may not optimize resources for either the agency or clients. Not all agencies assess client fees. This Level complies with agency requirements.	Methods for developing sliding scales are standardized, and some parts of the process are automated. Formats and data are standardized within the state. This Level includes additional data and quality edits.	BH-specific invoicing processes are phased out as the funding/payment requirements are aligned with national standards. Client invoicing processes are connected to or replaced by other agency systems and processes. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Sliding scale development is a tool built in to statewide HIE networks, allowing continual and automatic revision of the scale as source data is updated. Multiple sliding scales can be created, if desired, refined for different types of client resources and other factors. This Level adds client level data.	Sliding scales development is automatic and built in to HIE networks nationally. This Level adds nationwide technical interoperability.

Operations Management (OM)

OM: Determine Client Contribution					
Item	**Details**				
Description	The ***Determine Client Contribution*** business process describes the process by which client contribution towards payment is calculated. Fees may be assessed based on the client's ability to pay when certain services are not covered by other funding sources. The ***Determine Client Contribution*** business process begins with the evaluation of a client's financial means to determine ability to pay, usually as compared to the Federal Poverty Level. When a service is rendered, the client's ability to pay is reviewed against the service fee, and the fee is computed as a percentage of the service fee.				
MITA Reference	None				
Sample Data	Client financial data	Agency sliding scale			
OM: Determine Client Contribution: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The process is primarily paper based, manually adjusting paper bills and receipts. Bills and receipts are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing, and requires manual production of a client invoice. Not all agencies assess client fees. This Level complies with agency requirements.	The process automatically calculates the client contribution and produces the related invoice. Client contribution algorithms are standardized and automated within the agency. This Level includes additional data and quality edits.	BH-specific invoicing processes are phased out as the funding/payment requirements are aligned with national standards. Client invoicing processes are connected to or replaced by other agency systems and processes. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Providers/ contractors enter new service information into clinical records accessible to any authorized party through HIEs statewide, which can immediately determine client contribution. Access to client financial data also allows for real time adjustments to changing economic situations. This Level adds clinical data.	Client contributions can be automatically determined for any client for any service in any location in the country and immediately transmitted directly to the client through HIEs nationwide. This Level adds nationwide technical interoperability.	

Operations Management (OM)

OM: Prepare Client Invoice					
Item	**Details**				
Description	The ***Prepare Client Invoice*** business process begins with a scheduled invoicing timetable. The process includes retrieving client contribution data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing client invoices to recoup client fees.				
MITA Reference	None				
Sample Data	Client data		Client contribution data		
OM: Prepare Client Invoice: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The agency receives and produces paper invoices and EDI transactions using non-standard data and formats. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Paper transactions are batched and scanned (or data entered). Data is not comparable across agency and program silos. Not all agencies assess client fees. This Level complies with agency requirements.	The process automatically calculates the client contribution and produces the related invoice using basic business rules; and state agency specific standards. Grants/cost-based invoices are aligned to the HIPAA standards. This Level includes additional data and quality edits.	The process uses only standard EDI transactions, using Web mechanisms when possible to send the invoice to the client. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Process is terminated with full alignment with national standards.	NA	

Operations Management (OM)

OM: Collect Client Fees					
Item	**Details**				
Description	The ***Collect Client Fees*** business process begins with receiving client payment per an agency invoice. The process includes documenting the payment, entering the remittance amount, processing the payment, and formatting the results into required output data set for the accounting process.				
MITA Reference	None				
Sample Data	Client data		Client contribution data		
OM: Collect Client Fees: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The agency receives client fees in the mail using paper invoices and paper checks, using a largely manual process to open and sort mail, enter payments in the system, and record receipt. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. Not all agencies assess client fees. This Level complies with agency requirements.	The process automates more of the process, scanning invoices and checks upon receipt. Grants/cost-based payments are aligned to the HIPAA standards. This Level includes additional data and quality edits.	The process uses only standard EDI transactions via Web mechanisms, using Web mechanisms when possible to receive electronic payment from the client. BH-specific invoicing formats and data are phased out as the funding/payment requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Process is terminated with full alignment with national standards.	NA	

Operations Management (OM)

OM: Manage Drug Rebate		
Item	**Details**	
Description	The ***Manage Drug Rebate*** business process describes the process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes receiving quarterly drug rebate data from CMS, comparing it to quarterly payment history data, identifying drug data matches based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer.	
MITA Reference	Source Process Name: *Manage Drug Rebate* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	CMS Unit Rebate Amount (URA) Data Payment History	Drug Code Data Manufacturer Data

OM: Manage Drug Rebate: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily paper based using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing, and impact cost effectiveness. Data access is limited; reports and analyses are costly, untimely and may be inaccurate. Data and process is not comparable across agency and program silos. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with drug manufacturers, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state as agencies centralize rebate processes and drug utilization data from siloed programs to achieve economies of scale, increase coordination, improve rule application consistency, and standardize data to increase rebates. This Level includes additional data and quality edits.	Data is exchanged through automated electronic interchanges (interfaces) between agencies and drug manufacturers. The process has virtual access to clinical records. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Drug rebate is replaced by a new strategy of care and disease management using clinical data in HIEs statewide. Decision support and sophisticated analytic tools allow for care and disease management in real time. This Level adds clinical data.	The new process works through HIEs nationally and necessary information can be accessed to the extent authorized anywhere in the country. This access eliminates redundant collection and interchange of data, and improves real-time processing. This Level adds nationwide technical interoperability.

Operations Management (OM)

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

Operations Management (OM)

Item	Details	
Description	The ***Manage Recoupment*** business process describes the process of managing provider/contractor recoupment initiated by the discovery of an overpayment. The process then retrieves claims payment data, initiating the recoupment request, or adjudicates the claims adjustment request, notifying the provider/contractor of audit results, finally applying the refund in the system and monitoring payment history until the repayment is satisfied.	
MITA Reference	Source Process Name: *Manage Recoupment* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Payment History	Provider/Contractor data

OM: Manage Recoupment: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily manual using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Data and process is not comparable across agency and program silos. This Level complies with agency requirements.	The process is increasingly automated, incorporating direct connectivity to provider/contractor; Web interfaces for inquiries; basic business rules; and state agency specific standards. Formats and data are aligned with HIPAA and standardized within the state, and increased coordination between the provider/contractor utilization role, recoupments and accounting result in rule application consistency. This Level includes additional data and quality edits.	The process is fully automated and data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, as agencies centralize recoupment processes. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Claims and payment information is federated with HIEs statewide and can be accessed to the extent authorized. Real time processing makes claims data available almost immediately. This process is virtually eliminated with access to real time clinical and administrative data. This Level adds clinical data.	Claims and payment information is federated with HIEs nationally and can be accessed to the extent authorized anywhere in the country. This process is eliminated with access to real time clinical and administrative data. This Level adds nationwide technical interoperability.

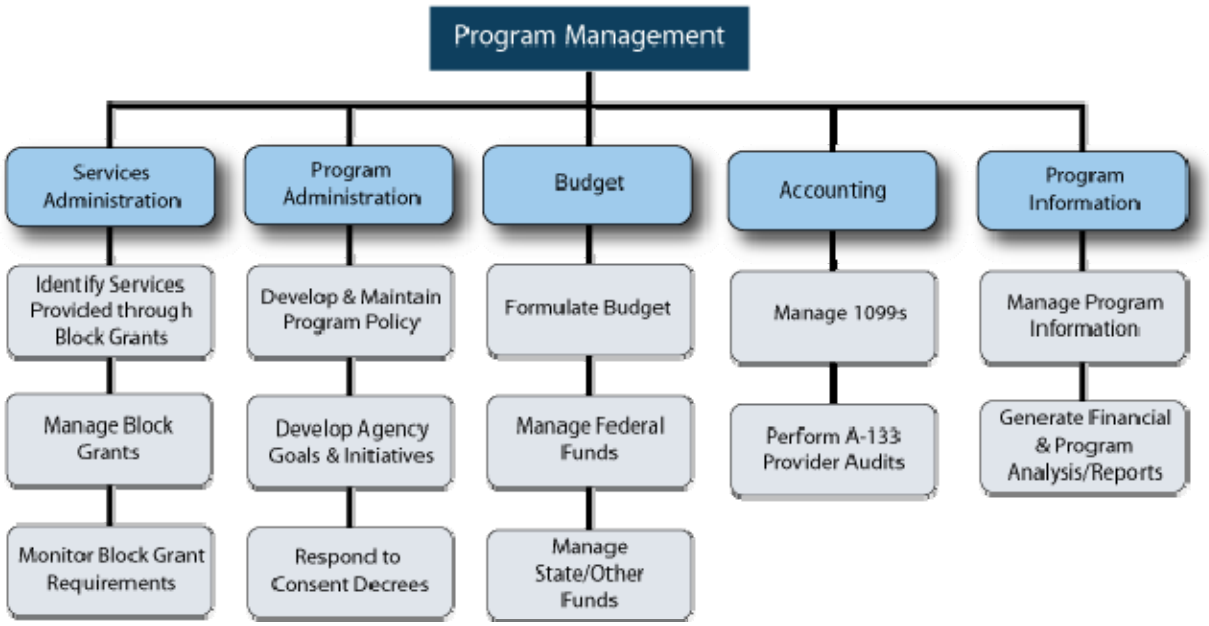
Operations Management (OM)

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

Operations Management (OM)

OM: Manage TPL Recovery					
Item	**Details**				
Description	The ***Manage Third Party Liability (TPL) Recovery*** business process receives third party liability data from various sources such as external and internal data matches, referrals, Attorneys, Fraud and Abuse units, providers/contractors and insurers, identifies the provider/contractor or TPL carrier, locates recoverable claims from payment history, creates post-payment recovery files, sends notification to other payers or providers/contractors, receives payment, sends receivable data, and updates payment history.				
MITA Reference	Source Process Name: *Manage TPL Recovery* Source Process Business Area: *Operations Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp				
Sample Data	Client data Insurer data Other Agency Data – DMV, Veterans Administration		Provider/contractor data Indian Health Service INS Fraud case file		
OM: Manage TPL Recovery: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The process is a mix of paper, phone, fax and proprietary EDI. Non-standardized data and format from multiple sources requires manual effort; processes are siloed across programs. The process is accomplished primarily via payer-to-provider/ contractor COB. The process is inconsistent in rule application rules, data reporting, and response timing. Data access is limited; reports and analyses are costly, untimely and may be inaccurate. This Level complies with agency requirements.	The process is increasingly automated, incorporating direct connectivity to provider/contractor; Web interfaces for inquiries; basic business rules; and state agency specific standards. Formats and data are aligned with HIPAA and standardized within the state. This Level includes additional data and quality edits.	The process is fully automated, and data and formats are standardized. The process uses BH-MITA standard interfaces for the payer to payer COB process reducing the burden to providers/ contractors and optimizing timeliness. Cross agency collaboration results in a one-stop shop with shared processes. At this Level data is standardized against HL7 RIM.	COB is automatically coordinated through regional HIEs. Client and provider/contractor information is accessible through HIEs statewide and can be accessed to the extent authorized. Response and payment outcomes are immediate. This Level adds clinical data.	Data exchange for COB occurs on a national scale. Client and provider/contractor information is federated with HIEs nationally and can be accessed to the extent authorized anywhere in the country. This process is minimized with access to real time clinical and administrative data. This Level adds nationwide technical interoperability.	

Program Management



Program Management (PM)

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

Program Management (PM)

PM: Develop and Maintain Program Policy		
Item	**Details**	
Description	The ***Develop and Maintain Program Policy*** business process responds to requests or needs for change in the agency's programs, services, or rules, based on federal or state statutes and regulations; governing board or commission directives; QIO findings; federal or state audits; agency decisions; and consumer and advocate pressure.	
MITA Reference	Source Process Name: *Develop and Maintain Program Policy* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Operations Management Client Information Provider/Contractor Information	Program Information Service Information Reference Information

PM: Develop and Maintain Program Policy: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Policy development occurs in an ad hoc manner on an irregular basis. Policy is developed by obtaining staff and stakeholder input and building broad based consensus through a labor intensive process of in person meetings and iterative documents. The process is primarily informed by individual opinions and perspectives, not data. This Level complies with agency requirements.	Policy development occurs on a regularly scheduled basis using a systematic and well-defined process. The process uses the Web, video teleconferencing and other technologies to facilitate communications and process speed. The process is informed by a set of agency standardized data on clients and services. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external stakeholders. Communications are standardized across agencies and coordination cross agency results in improved coordination for policy activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Standardized client specific clinical data is accessible for policy development via state HIEs, and data for policy activities is automatically communicated. All health care agencies collaborate in policy communications between agencies and among all agency partners statewide. This Level adds clinical data.	Policy development protocols are integrated into HIEs on a national scale. Data pertinent to the policy process is analyzed and transmitted in real time, shortening development time. Nationwide collaborations streamline policy communications with agency stakeholders nationwide. This Level adds nationwide technical interoperability.

Program Management (PM)

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

Program Management (PM)

PM: Manage Federal Funds		
Item	**Details**	
Description	Funding sources for BH services may come from a variety of sources and are often spread across programs. The ***Manage Federal Funds*** business process monitors federal funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.	
MITA Reference	Source Process Name: *Manage State Funds* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Client Information Provider/contractor Information Accounting Tables	State Financial Management Applications Payment History

PM: Manage Federal Funds: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The business process is focused primarily on meeting reporting requirements as required as conditions for funding. The process uses primarily paper/ phone/fax based processing and some proprietary internal systems, using non-standard formats and data making reporting and analysis difficult. The process is inconsistent in rules application, data reporting, and response timing. Most data used is administrative and reporting; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces to cross agency funding data. Formats and data are standardized within the state. All programs use HIPAA X12 standards for claims and other billing and payment transactions. Process automation improves timeliness of compiling funding history. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. BH-specific funding requirements are phased out and aligned with national standards, allowing cross program comparison. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Funding information is accessible to any authorized party through HIEs statewide. Real time payment processing makes current funding figures available almost immediately. Decision support and sophisticated analytic tools allow for ad hoc analysis and reporting in real time. Pointers to selected clinical information link it to funding data to allow ongoing monitoring. Additional information on other funding sources is available for use in this process. This Level adds clinical data.	Funding information is federated with HIEs nationally so that any stakeholder can access funding information to the extent authorized nationwide. Complete virtual clinical record and administrative data access facilitates real time analysis and decisions. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. Most services are instantly authorized or denied from point of service; payment is automatically established without need of invoice. This Level adds nationwide technical interoperability.

Program Management (PM)

PM: Manage Block Grants		
Item	**Details**	
Description	Funding sources for BH services may come from a variety of sources and are often spread across programs. The ***Manage Block Grants*** business process monitors federal funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.	
MITA Reference	None.	
Sample Data	Client Information Provider/contractor Information Accounting Tables	State Financial Management Applications Payment History

PM: Manage Block Grants: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The business process is focused primarily on meeting reporting requirements as required as conditions for funding. The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using non-standard formats and data making reporting and analysis difficult. The process is inconsistent in the application of the rules, data reporting, and response timing. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces to cross agency funding data. Formats and data are standardized within the state. All programs use HIPAA X12 standards for claims and other billing and payment transactions. Process automation improves timeliness of compiling funding history. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. BH-specific funding requirements are phased out and aligned with national standards, allowing cross program comparison. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Funding, client, service and outcome information is accessible to any authorized party through HIEs statewide. Real time payment processing makes current funding figures available almost immediately. Block grant management is eliminated as a separate process. This Level adds clinical data.	N/A

Program Management (PM)

PM: Identify Block Grant Services		
Item	**Details**	
Description	The ***Identify Block Grant Services*** business process determines the services to be supported through grants. The process examines current state needs, services and trends, estimates service costs, obtains planning council and other stakeholder input, assesses external factors affecting the service plan, assesses agency initiatives and plans, and produces a final service plan.	
MITA Reference	None.	
Sample Data	Client Information Outcomes and performance measures Budget and expenditure history	Services history Past block grant applications Block grant history

PM: Identify Block Grant Services: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identification of block grant services occurs in an ad hoc manner as grants are obtained. Identification of services is accomplished by obtaining staff and stakeholder input and building broad based consensus through a labor intensive process of in person meetings and iterative documents. The process is primarily informed by individual opinions and perspectives, using limited service and outcome data. This Level complies with agency requirements.	Identification of block grant services occurs on a scheduled basis using a systematic and well-defined process. The process uses the Web, video teleconferencing and other technologies to facilitate communications and process speed. The process is informed by a set of agency standardized data on clients, services and outcomes. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external stakeholders. Separate data and process requirements are phased out as the funding/payment and reporting requirements are aligned with national standards. Communications are standardized across agencies and coordination cross agency results in improved coordination for service identification activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Service information is accessible to any authorized party through HIEs statewide for planning purposes. Identification of block grant services is eliminated as a separate process. This Level adds clinical data.	N/A

Program Management (PM)

PM: Monitor Block Grant Requirements		
Item	**Details**	
Description	The ***Monitor Block Grant Requirements*** business process monitors the services provided and outcomes achieved through block grant funding. The process regularly examines the most current provider/contractor data on service delivery and costs, service coverage and improvement, client outcomes, grant expenditures and other factors as required by the grant.	
MITA Reference	None.	
Sample Data	Client Information Outcomes and performance measures Budget and expenditure history	Services information Past block grant data Provider/contractor history

PM: Monitor Block Grant Requirements: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is done with a mix of tape, CD and some proprietary internal systems, using non-standard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and multiple reviews may be conducted by different programs. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. The process is informed by a set of agency standardized data on clients, services and outcomes. This Level includes additional data and quality edits.	The process uses networks or virtual connections to both internal and external data and stakeholders. Separate data and process requirements are phased out as the funding/payment and reporting requirements are aligned with national standards. Coordination cross agency improves coordination of monitoring activities. The process is informed by nationally standardized, cross agency data accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Client, service, and provider/contractor information is accessible to any authorized party through HIEs statewide for monitoring purposes. Monitoring of block grant services is eliminated as a separate process. This Level adds clinical data.	N/A

Program Management (PM)

PM: Manage State Funds		
Item	**Details**	
Description	Funding sources for BH services may come from a variety of sources and are often spread across programs. The ***Manage State Funds*** business process monitors state and other funds through ongoing tracking and reporting of expenditures and ensures accuracy in reporting of funding sources. Management of other funding sources likely overlaps with this process.	
MITA Reference	Source Process Name: *Manage State Funds* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Client Information Provider/contractor Information Accounting Tables	State Financial Management Applications Payment History

PM: Manage State Funds: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The business process is focused primarily on meeting reporting requirements as required as conditions for funding. The process uses primarily paper/ phone/fax based processing and some proprietary internal systems, using non-standard formats and data making reporting and analysis difficult. The process is inconsistent in rules application, data reporting, and response timing. Most data used is administrative and reporting ; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces to cross agency funding data. Formats and data are standardized within the state. All programs use HIPAA X12 standards for claims and other billing and payment transactions. Process automation improves timeliness of compiling funding history. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. BH-specific funding requirements are phased out and aligned with national standards, allowing cross program comparison. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Funding information is accessible to any authorized party through HIEs statewide. Real time payment processing makes current funding figures available almost immediately. Decision support and sophisticated analytic tools allow for ad hoc analysis and reporting in real time. Pointers to selected clinical information link it to funding data to allow ongoing monitoring. Additional information on other funding sources is available for use in this process. This Level adds clinical data.	Funding information is federated with HIEs nationally so that any stakeholder can access funding information to the extent authorized nationwide. Complete virtual clinical record and administrative data access facilitates real time analysis and decisions. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. Most services are instantly authorized or denied from point of service; payment is automatically established without need of invoice. This Level adds nationwide technical interoperability.

Program Management (PM)

PM: Manage 1099s		
Item	**Details**	
Description	The ***Manage 1099s*** business process describes the process by which 1099 tax forms are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number. The process receives payment and/or recoupment data from the ***Price Claim/Value Encounter*** Process or from the ***Manage Settlements*** process. The process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies as needed. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.	
MITA Reference	Source Process Name: *Manage 1099s* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	***Price Claim/Value Encounter*** process data	***Manage Settlements*** process data

PM: Manage 1099s: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Programs are siloed and multiple 1099s may be created by different payment systems. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with business partners, basic business rules, and enhanced consistency of responses and timing. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Data and formats are standardized nationally. Cross agency collaboration results in shared processes. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized.	This business process interfaces with other processes through HIEs statewide. This Level adds clinical data.	The process has process collaboration and full interoperability with other local, state, and federal programs with national virtual administrative data access and exchange. This Level adds nationwide technical interoperability.

Program Management (PM)

PM: Perform A-133 Provider Audits		
Item	**Details**	
Description	The ***Perform A-133 Provider Audits*** business process describes the process by which the agency requests and receives audits required by Federal grant recipients. The process involves reviewing audits, and conducting follow up on findings and questionable costs. The OMB A-133 compliance supplement is an extensive guide for auditing Federal grants and their respective recipients.	
MITA Reference	None.	
Sample Data	Service data Provider/Contractor data Federal grant data	Payment data Provider/contractor accounting data

PM: Perform A-133 Provider Audits: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process is primarily paper/phone/fax based, using non-standard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and multiple reviews may be conducted by different programs. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with providers/ contractors, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Data and formats are standardized nationally. Cross agency collaboration results in shared review processes. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized.	This business process interfaces with other review and audit processes through HIEs statewide. This Level adds clinical data.	The process uses process collaboration and has full interoperability with other local, state, and federal programs with national virtual administrative data access and exchange. This Level adds nationwide technical interoperability.

Program Management (PM)

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

Program Management (PM)

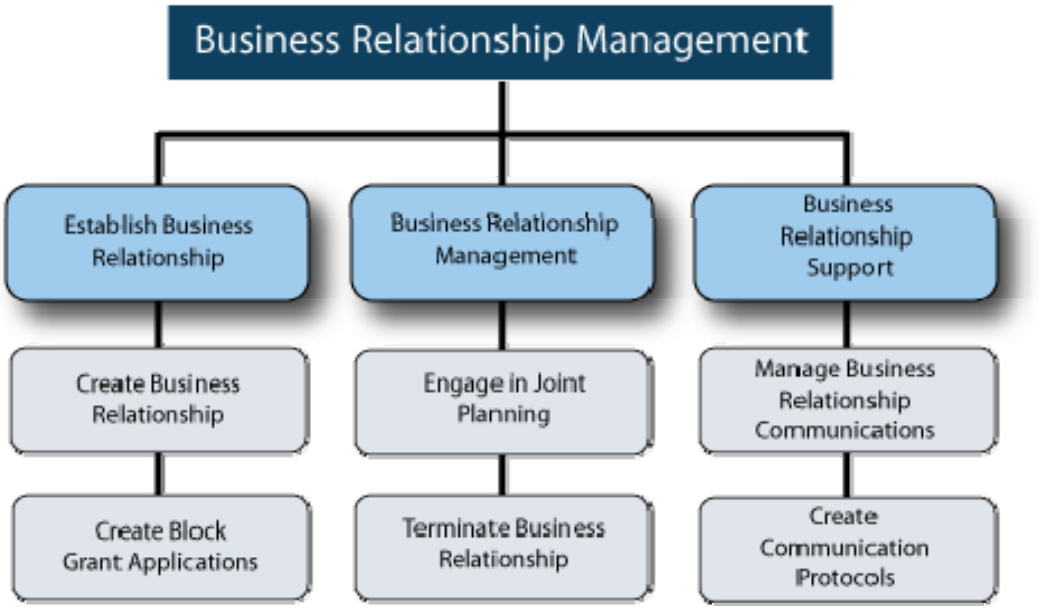
PM: Manage Program Information		
Item	**Details**	
Description	The ***Manage Program Information*** business process is responsible for managing all the operational aspects of the Program Information Repository, the source of comprehensive program information used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information Repository receives requests to add, delete, or change data in program records.	
MITA Reference	Source Process Name: *Manage Program Information* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Program quality measure data Service data store: Services and provider/contractor types covered; program policy; and contract information Client data store: Client demographics, service data; applicant/client financial, social, functional and clinical data	Provider/Contractor data store: Provider/contractor data, such as type, location, availability, gender, linguistic and cultural competence Claims history; encounter history; payment history data stores Care Management population health data

PM: Manage Program Information: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. Inquiries are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses clinical data to improve monitoring. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with some shared processes. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Program information is accessible to any authorized party through HIEs statewide. Pointers to selected clinical information allow ongoing monitoring and quality control. This Level adds clinical data.	Full interoperability with other local, state, and federal programs with complete virtual clinical record and administrative data access. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. This Level adds nationwide technical interoperability.

Program Management (PM)

PM: Respond to Consent Decrees					
Item	**Details**				
Description	The ***Respond to Consent Decrees*** process receives and requests consent permissions, stores those permissions, locates the permissions when a specific client's information is requested, ensures that the permissions are followed, and forwards the permissions with the requested data.				
MITA Reference	None.				
Sample Data	Client data	Consent data			
PM: Respond to Consent Decrees: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The process is primarily paper/phone/fax based using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. Incorporation of all applicable requirements (HIPAA, 42 CFR pt. 2) may be variable. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces, basic business rules, and enhanced consistency of responses and timing. Formats and data are standardized within the state. Inquiries are received and responded to electronically. This Level includes additional data and quality edits.	Consent decrees are fully automated and linked to the client's clinical data. The process has virtual access to administrative and clinical records; self adjusting business rules. Data and formats are standardized statewide. Cross agency collaboration results in a one-stop shop, with shared access to consent decrees. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Consent decrees associated with client records are accessible to any authorized party through HIEs statewide. All applicable consent requirements are consolidated and standardized nationally. This Level adds clinical data.	Full interoperability with other local, state, and federal programs with complete virtual clinical record and consent decree access. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time action. This Level adds nationwide technical interoperability.	

Business Relationship Management



Business Relationship Management (BRM)

BRM: Create Business Relationship		
Item	**Details**	
Description	The ***Create Business Relationship*** business process encompasses activities undertaken by the State BH agency to enter into a variety of business partner relationships, usually with other government agencies. These arrangements include Memoranda of Understanding (MOUs), interagency contracts and service agreements, health information exchange (HIE) agreements, access and capacity agreements,	
MITA Reference	Source Process Name: *Establish Business Relationship* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Standard contract/agreement template Data from previous contract/agreement for same party	Business rules for contracts/agreements Comparable information on other contracts/agreements

BRM: Create Business Relationship: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily manual, using non-standard formats and data. MOU formats and requirements may be variable across agencies and require negotiations and involvement of legal counsel. The process is often lengthy and inconsistent in the application of the rules. This Level complies with agency requirements.	The process incorporates direct connectivity across agencies; Web interfaces; basic business rules; and enhanced consistency of process and timing. MOU formats and data are standardized within state health agencies, and negotiations are conducted online. MOU creation is more automated, so consistency and completion time is improved. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. MOU formats and data are standardized and automated within all state health agencies, with shared processes for some steps. Rules are consistently applied and legal staff can review and approve online, reducing completion time. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	MOU formats, data and processes are standardized and automated across all government agencies at all levels in the state. The process uses virtual administrative records and integrated systems reduce completion time to the minimum feasible. Standards reduce or eliminate the need for extensive legal review. This Level adds clinical data.	MOU formats and data are standardized and automated across government agencies at all levels nationwide. The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual administrative data access. Completion time is optimized. This Level adds nationwide technical interoperability.

Business Relationship Management (BRM)

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

BRM: Manage Business Relationship: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
The process uses primarily paper/phone/fax based processing and some proprietary internal systems, using non-standard formats and data. The process is inconsistent in the application of the rules, data reporting, and response timing. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with business partners, basic business rules, and enhanced consistency of responses and timing. Agreement formats and data are standardized within the state. Communications are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Business partner information is accessible to any authorized party through HIEs statewide. Additional business partner data are available for use in this process. This Level adds clinical data.	The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual administrative data access. The process uses national guidelines and best practices, and eliminates redundant collection and interchange of data and improves real-time monitoring. This Level adds nationwide technical interoperability.

Business Relationship Management (BRM)

BRM: Manage Business Relationship Communications				
Item	**Details**			
Description	The ***Manage Business Relationship Communication*** business process produces and assures routine and ad hoc communications between the business partners.			
MITA Reference	Source Process Name: *Manage Business Relationship Communication* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Content for communication			
BRM: Manage Business Relationship Communications: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily via paper, telephone, & fax; inquiries are received from various sources using non-standard formats. The process is inconsistent in the application of the rules and in response timing. Communication is not coordinated among multiple, siloed programs and not systematically triggered by agency-wide processes. This Level complies with agency requirements.	The process incorporates Web interfaces; basic business rules; and state agency specific standards. Routine communications with business partners are standardized and automated within the agency. This Level includes additional data and quality edits.	The process operates through virtual access to business partners. Communications are standardized within the agency and coordination cross agency results in improved efficiencies. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Business partner communications are handled through HIEs statewide, and regular communications are automatic. All health care agencies collaborate in communications between agencies and among all business partners statewide. This Level adds clinical data.	Business partner communications are handled through HIEs nationally. Nationwide collaborations streamline communications with business partners anywhere in the country. This Level adds nationwide technical interoperability.

Business Relationship Management (BRM)

BRM: Create Communications Protocols		
Item	**Details**	
Description	The ***Create Communications Protocols*** business process establishes mechanisms and requirements for routine and ad hoc communications between agency business partners. This requirement at present primarily governs communications protocols between substance abuse agencies, child welfare agencies and the courts, where consideration of the confidentiality requirements and legal requirements on all sides is critical to determine what data can be shared.	
MITA Reference	None	
Sample Data	Communications rules	Confidentiality requirements

BRM: Create Communications Protocols: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Communications protocols are determined in an ad hoc manner on a case by case basis. Communications are largely sent and received in non-standard formats, mostly via phone, fax, or USPS. Communications are not coordinated among multiple, siloed programs and not systematically triggered by agency-wide processes. This Level complies with agency requirements.	Communications protocols exist and are consistently applied. The process uses Web interfaces; basic business rules; and state agency specific standards. Routine communications are standardized and automated within the agency. This Level includes additional data and quality edits.	The process operates through virtual connections to agency partners. Communications are standardized within the agency and coordination cross agency results in improved efficiencies. Communications protocols are automated as business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Communications protocols are integrated into state HIEs and regular communications are automatic. All health care agencies collaborate in communications between agencies and among all agency partners statewide.	Communications protocols are integrated into HIEs on a national scale. Nationwide collaborations streamline communications with agency partners anywhere in the country. This Level adds nationwide technical interoperability.

Business Relationship Management (BRM)

BRM: Create Block Grant Applications		
Item	**Details**	
Description	The ***Create Block Grant Applications*** business process encompasses activities undertaken by the BH agency to solicit provider and contractor applications to provide services.	
MITA Reference	Source Process Name: *Establish Business Relationship* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Standard application template Data from previous applications	Business rules for applications Federal requirements for applications

BRM: Create Block Grant Applications: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily manual, using non-standard formats and data. Application formats and requirements may be variable across agencies and require negotiations and involvement of legal counsel. The process is often lengthy and inconsistent in the application of the rules. This Level complies with agency requirements.	The process incorporates direct connectivity across agencies; Web interfaces; basic business rules; and enhanced consistency of process and timing. Application formats and data are standardized within state health agencies, and negotiations are conducted online. Applications creation is more automated, so consistency and completion time is improved. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Separate applications formats and data are phased out as the funding/payment and application requirements are aligned with national standards. This allows process alignment with other state agencies and use of existing automated systems and business rules. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Applications are no longer required and the payment process now conforms to industry norms. This process is terminated.	This process is terminated.

Business Relationship Management (BRM)

BRM: Engage in Joint Planning		
Item	**Details**	
Description	The ***Engage in Joint Planning*** business process coordinates efforts and programs between agency business partners that have similar goals, objectives, and target populations. Although the goals and objectives may be similar, the specific activities undertaken are often very different but may represent complementary approaches, or comprehensive approaches when combined, to improving client health, treatment, and services.	
MITA Reference	None	
Sample Data	Agency and program goals, objectives, and target populations	Agency and program activities

BRM: Engage in Joint Planning: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Agency programs, services, and communications are not coordinated among multiple, siloed programs and not systematically connected by agency-wide processes. The planning process is primarily manual, using non-standard formats and data. Program and service requirements may be variable across agencies and difficult to change. The process is often lengthy and produces inconsistent results. This Level complies with agency requirements.	Agency programs, activities, and services are developed and implemented in coordination with other related programs within the same agency. The process uses Web interfaces; basic business rules; and state agency specific standards. Routine communications are standardized and automated within the agency, and negotiations are conducted online. This Level includes additional data and quality edits.	Agency programs, activities, and services are developed and implemented in coordination with other health programs in different agencies. The process operates through virtual connections to agency partners; communications and cross agency coordination are standardized. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Agency programs, activities, and services are coordinated with other related programs among all business partners statewide. Coordination activities and connections across agencies are automated and widely available via HIEs. Additional data is available to augment coordination activities and drive broader planning and service implementation. This Level adds clinical data.	Health programs, activities, and services are coordinated on a national scale using interconnected HIEs. Nationwide collaborations streamline communications with agency partners anywhere in the country. A seamless national care and services network provides optimum care to clients and offers a single point for accessing any type of care and services anywhere in the country. This Level adds nationwide technical interoperability.

Business Relationship Management (BRM)

BRM: Terminate Business Relationship				
Item	**Details**			
Description	The ***Terminate Business Relationship*** business process cancels the agreement between the State BH agency and the business partner.			
MITA Reference	Source Process Name: *Terminate Business Relationship* Source Process Business Area: *Business Relationship Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp			
Sample Data	Content for response			
BRM: Terminate Business Relationship: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Communications and information exchange for this business process is primarily via paper, telephone, & fax. The process is inconsistent in the application of the rules and in response timing, and uses multiple data formats and semantics. This Level complies with agency requirements.	The process incorporates Web interfaces for business partner agreements; basic business rules; and enhanced consistency of responses and timing. Communications are received and responded to electronically. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	This process is conducted using virtual records through HIEs statewide. Additional business partner data are available for use in this process. This Level adds clinical data.	The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual administrative data access. The process accesses national guidelines and best practices. This Level adds nationwide technical interoperability.

Accountability Management

Accountability Management (AM)

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

Accountability Management (AM)

AM: Manage Case		
Item	**Details**	
Description	The ***Manage Case*** business process receives a case file from an investigative unit with the direction to respond to the case, participate in the case, or pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or client from the program; or the case may be terminated or suspended. Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external investigation.	
MITA Reference	Source Process Name: *Manage Case* Source Process Business Area: *Program Integrity Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Member Information Provider Information Payment History Information	Benefits/Reference Information Program Information Medical records requested from providers

AM: Manage Case: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily manual, using non-standard formats and data. Requirements may be variable across agencies. The process is often lengthy and inconsistent in the application of the rules. This Level complies with agency requirements.	The process incorporates direct connectivity across agencies; Web interfaces; basic business rules; and enhanced consistency of process and timing. Formats and data are standardized within state health agencies, and information can be shared online. Increased availability of data electronically aids the investigation process. Case investigation is more automated, so consistency and timeliness is improved. This Level includes additional data and quality edits.	The process has virtual access to administrative records and self adjusting business rules. Formats and data are standardized and automated within all state health agencies, and processes are shared and coordinated. Case investigation can be facilitated by automated review of the data, and rules are consistently applied. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Formats, data and processes are standardized and automated using HIEs across all government agencies at all levels in the state. The process uses virtual administrative records and integrated systems to further the investigation. Standards and cross agency communication reduce time needed to complete the investigation. This Level adds clinical data.	Formats, data and processes are standardized and automated using HIEs across all government agencies at all levels nationwide. The process has point-to-point collaboration and full interoperability with other local, state, and federal programs with complete virtual access to administrative and clinical data. This Level adds nationwide technical interoperability.

Accountability Management (AM)

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

Accountability Management (AM)

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

Accountability Management (AM)

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

Accountability Management (AM)

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

Accountability Management (AM)

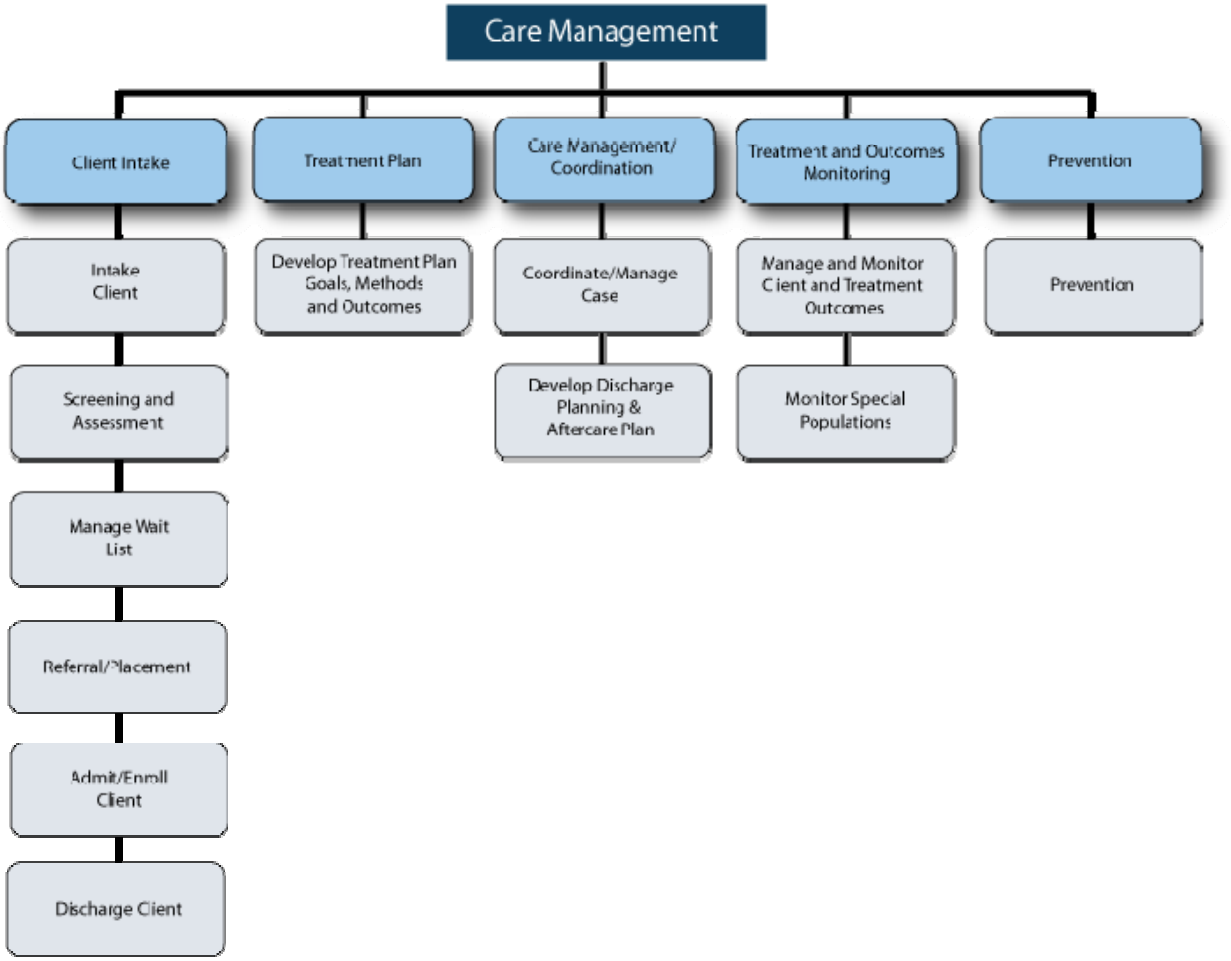
AM: Monitor Performance and Business Activity		
Item	**Details**	
Description	The ***Monitor Performance and Business Activity*** process utilizes the mechanisms and measures that were developed by the agency. The process includes the steps involved in implementing the mechanisms and measures to track agency activity and effectiveness at all levels. Examples include episodes of care, performance measures, outcomes measures, and quality measures.	
MITA Reference	Source Process Name: *Monitor Performance and Business Activity* Source Process Business Area: *Program Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	All Enterprise data State and federal measures	Shared analytical data

AM: Monitor Performance and Business Activity: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Monitoring activities are primarily done using information from a mix of tape, CD and some proprietary internal systems, using non-standard formats and data. The process is inconsistent in the application of the rules, reporting, and response timing. Programs are siloed and similar activities may be conducted by different programs. Most data used is administrative and reporting data; analysis use is costly and resource intensive. This Level complies with agency requirements.	The process is increasingly automated, incorporating Web interfaces with other agencies, programs, and data; basic business rules, and enhanced consistency of responses and timing. The process is informed by a set of agency standardized data on clients and services. This Level includes additional data and quality edits.	The process has virtual access to administrative and clinical records; self adjusting business rules; and uses some clinical data to improve monitoring. Data and formats are standardized nationally. Cross agency collaboration results in a one-stop shop, with shared monitoring processes. Monitoring metrics are synchronized across agencies. The process is informed by nationally standardized. Cross agency data is accessible via interfaces that use BH-MITA standards compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	This business process is integrated into monitoring processes through HIEs statewide. This Level adds clinical data.	The process is fully integrated into and interoperable with other local, state, and federal programs with national real time, virtual administrative data access and exchange. This Level adds nationwide technical interoperability.

Accountability Management (AM)

AM: Initiate Accreditation					
Item	**Details**				
Description	The ***Initiate Accreditation*** process provides assistance to providers/contractors in achieving and maintaining the accreditation and credentialing necessary for program participation.				
MITA Reference	None.				
Sample Data	Provider/contractor data		Accreditation and credentialing requirements		
AM: Initiate Accreditation Process: Maturity Levels					
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	
The process is largely conducted manually and in an ad hoc manner. Materials are prepared and updated manually, and communications are by mail or in person. The process varies across multiple, siloed programs is uncoordinated, and nonstandard. Quality and consistency is variable. This Level complies with agency requirements.	Increased use of agency standards improves communication of information and technical assistance. Electronic materials and interfaces are available via a Web portal. Standard accreditation information is maintained and distributed to providers/ contractors via electronic media. This Level includes additional data and quality edits.	Accreditation assistance is available via state Web portals using BH-MITA and MITA standard data and interfaces and shared with other collaborating agencies. Accreditation and credentialing forms and processes are mostly conducted online, the process is tracked and completion documented. At this Level data is standardized against HL7 RIM.	Accreditation assistance is largely handled through HIEs statewide; alerts are automatic. All health care agencies collaborate in assisting providers/ contractors statewide with accreditation. Providers/ contractors can alert the agency electronically for assistance. This Level adds clinical data.	Accreditation assistance is largely handled through HIEs nationally; states can centralize assistance through HIEs as well. Nationwide collaborations streamline assistance to providers/ contractors anywhere in the country. This Level adds nationwide technical interoperability.	

Care Management (CM)



Care Management (CM)

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

Care Management (CM)

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

Care Management (CM)

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

Care Management (CM)

CM: Admit/Enroll Client Process		
Item	**Details**	
Description	The ***Admit/Enroll Client*** business process admits a client to a particular facility and/or enrolls a client in a particular program. The process receives data from the ***Intake Client*** and ***Screening and Assessment*** processes, identifies additional client data needs for admission and enrollment in specific facilities and programs (financial, diagnostic, geographic), sends the data to client and provider/contractor databases or interfaces, and notifies the client and providers/contractors. **NOTE:** There is a separate business process for *Discharge Client*.	
MITA Reference	Source Process Name: *Enroll Member* Source Process Business Area: *Member Management* References: Part 1 Appendix C, Business Process Model Details Part 1 Appendix D, Business Process Capability Matrix Details http://www.cms.hhs.gov/MedicaidInfoTechArch/04_MITAFramework.asp	
Sample Data	Client information	Admitting provider/contractor information

CM: Admit/Enroll Client: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Client fills out one or more paper forms for various programs and services. This business process is primarily conducted via paper using non-standard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are not HIPAA compliant, and are likely state-specific, using state-specific business rules. Data is not comparable across agency and program silos. This Level complies with agency requirements.	Client fills out only one form for various programs and services. The process incorporates direct connectivity to provider/contractor; Web interfaces; basic business rules; and state agency specific standards. Data and formats are aligned to conform to national standards. Admission and enrollment processes are standardized and automated within the agency. This Level includes additional data and quality edits.	Admission and enrollment are merged into a single process and coordinated across agencies and programs. The process is fully automated and uses clinical records to assist the admission/ enrollment process. Cross agency collaboration results in a one-stop shop, with shared processes for some steps. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	Admission and enrollment processes are automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and provider/contractor data. Provider/ contractor alerts are fully automated; admission and enrollment information is self-populated. This Level adds clinical data.	Admission and enrollment processes are automated through HIEs nationwide. The process automatically verifies the data, designs a client specific service package; and admits/enrolls the client in specific facilities and programs. This Level adds nationwide technical interoperability.

Care Management (CM)

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

Care Management (CM)

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

Care Management (CM)

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

Care Management (CM)

CM: Manage and Monitor Client and Treatment Outcomes		
Item	**Details**	
Description	The ***Manage and Monitor Client and Treatment Outcomes*** business process uses Federal and State-specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes client and client population outcomes. It includes activities to track and assess effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. It also includes ongoing monitoring, management, and reassessment of services and treatment plans for need, appropriateness, and effectiveness, and monitoring of special client populations (block grant, pregnant women and children, and HIV/intravenous drug users).	
MITA Reference	None.	
Sample Data	Client information Provider/contractor information Payment history Information Service information	Case history Assessment protocol Treatment plan protocol

CM: Manage and Monitor Client and Treatment Outcomes: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper using non-standard forms and data. The process is inconsistent in the application of the rules and in response timing. Format and content are non-standard, and are likely state-specific, using state-specific business rules. Monitoring and outcomes are not coordinated across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to other agencies, programs, and providers/ contractors using Web interfaces; some basic business rules and state agency specific standards are in place. Data and formats are aligned to conform to national standards. Monitoring and outcomes processes are standardized and automated within the agency; some coordination occurs. This Level includes additional data and quality edits.	The process is fully automated. Cross agency collaboration results in improved monitoring and outcomes coordination, and some processes are shared. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and treatment plan data. All care participants are automatically notified and updated when new information is available, and mechanisms are in place to quickly and easily track progress and make informed adjustments. This Level adds clinical data.	Care management processes are automated through HIEs nationwide. The process automatically gathers and verifies the data, treatment teams are virtually convened, and decisions made promptly using evidence-based practices. Continuous tracking allows real time adjustment of agency and treatment goals for improving care practices. This Level adds nationwide technical interoperability.

Care Management (CM)

CM: Develop Treatment Plan Goals, Methods, Outcomes		
Item	**Details**	
Description	The ***Develop Treatment Plan Goals, Methods, Outcomes*** business process uses Federal and State-specific criteria, rules, best practices and professional judgment to develop client treatment plans that optimizes successful outcomes. It includes involving a team of professionals to engage in activities to track and assess the client and his/her treatment progress both on intake and throughout the care process, establish and adapt a care plan tailored to changing client needs, and establish achievable goals and an appropriate mix of treatment and support services.	
MITA Reference	None.	
Sample Data	Client information Provider/contractor information Payment history Information Service information	Case history Assessment protocol Treatment plan protocol

CM: Develop Treatment Plan Goals, Methods, Outcomes: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper, phone, and fax using non-standard forms and data. The process is inconsistent in approach and timing. Format and content are non-standard, and are likely state-specific, using state-specific business rules. Treatment plan development is not coordinated across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to other agencies, programs, and providers/ contractors using Web interfaces to facilitate development; some basic business rules and state agency specific standards are in place. Data and formats are aligned to conform to national standards. Treatment plan development processes are standardized and automated within the agency; some coordination occurs. This Level includes additional data and quality edits.	The process is fully automated. Cross agency collaboration results in improved coordination of treatment plan development activities; some processes are shared. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and any previous treatment plan data. All care participants are automatically notified and updated when new information is available, and mechanisms are in place to quickly and easily track progress and make informed changes to the treatment plan. This Level adds clinical data.	Treatment plan development processes are automated through HIEs nationwide. The process automatically gathers and verifies the data, treatment teams are virtually convened, and decisions made promptly using evidence-based practices. Continuous tracking allows real time adjustment of treatment goals to maximize successful outcomes. This Level adds nationwide technical interoperability.

Care Management (CM)

CM: Develop Discharge Planning and Aftercare Plan		
Item	**Details**	
Description	The ***Develop Discharge Planning and Aftercare Plan*** business process uses Federal and State-specific criteria, rules, best practices and professional judgment to develop discharge planning and aftercare plans that optimize successful outcomes. It includes activities to track and assess the client and his/her treatment progress during the episode of care and status at discharge, evaluate client needs for ongoing care and support services, and establish a long term plan for continuing and/or sustaining recovery.	
MITA Reference	None.	
Sample Data	Client information Provider/contractor information Payment history Information Service information	Case history Assessment protocol Treatment plan protocol

CM: Develop Discharge Planning and Aftercare Plan: Maturity Levels				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
This business process is primarily conducted via paper, phone, and fax using non-standard forms and data. The process is inconsistent in approach and timing. Format and content are non-standard, and are likely state-specific, using state-specific business rules. Discharge/aftercare plan development is not coordinated across agency and program silos. This Level complies with agency requirements.	The process incorporates direct connectivity to other agencies, programs, and providers/ contractors using Web interfaces to facilitate development; some basic business rules and state agency specific standards are in place. Data and formats are aligned to conform to national standards. Discharge/aftercare plan development processes are standardized and automated within the agency; some coordination occurs. This Level includes additional data and quality edits.	The process is fully automated. Cross agency collaboration results in improved coordination of discharge/aftercare plan development activities; some processes are shared. Interfaces use BH-MITA standardized data and are compatible with Medicaid MITA. At this Level data is standardized against HL7 RIM.	The process is automated using point-to-point collaboration through HIEs statewide. The process has automated access to clinical and treatment plan data. Plan participants are automatically notified when the client is ready to discharge, and mechanisms are in place to quickly and easily track client progress and status to develop appropriate discharge/aftercare plans. This Level adds clinical data.	Discharge/aftercare plan development processes are automated through HIEs nationwide. The process automatically gathers and verifies the data, teams are virtually convened, and decisions made promptly using evidence-based practices. Continuous tracking allows real time adjustment of discharge/aftercare goals to maximize successful recovery. This Level adds nationwide technical interoperability.

Care Management (CM)

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

Appendix D List of Acronyms

Listed below is an all-inclusive list of acronyms and definitions used for the BH MITA project.

Acronym	Definition
42 CFR pt. 2	Federal Substance Abuse Facility Confidentiality Law
AA	Application Architecture; Attribute Authority
Accelerator	Factors that facilitate or enable specific outcomes
ACL	Access Control List
ADA	American Dental Association
AHA	American Hospital Association
AHIC	American Health Information Community
AMA	American Medical Association
ANSI	American National Standards Institute
APC	Ambulatory Patient Classification
APD	Advance Planning Document
As-Is	Current state; business as it operates today
ASC	Accredited Standards Committee
ASN	Abstract Syntax Notation
ASP	Application Service Provider
ASTM	American Society for Testing and Materials
ATR	Access to Recovery services
AVR	Automated Voice Response
B2B	Business-to-Business
BA	Business Architecture; Business Areas; Business Associate Agreement
BAFO	Best and Final Offer
BC	Business Capability
BCM	Business Capability Matrix
BENDEX	Beneficiary Data Exchange
BH	Behavioral Health
BH-MITA	Behavioral Health-Medicaid Information Technology Architecture
BHO	Behavioral Health Organization
BHR	Behavioral Health Record
BHS	Behavioral Health Standards
BP	Business Process
BPDM	Business Process Definition Metamodel
BPEL	Business Process Execution Language
BPM	Business Process Model
BPMN	Business Process Management Notation
BPPC	Basic Patient Privacy Consents

Acronym	Definition
BPSS	Business Process Specification Schema
BRM	Business Relationship Management
BS	Business Services
BTOM	Brief Treatment Outcomes Measure
BSDP	Business Service Definition Package
Business capability	A business process at a specific level of maturity
CA	Certificate Authority
CCHIT	Certification Commission for Healthcare Information Technology
CCOW	Clinical Context Object Workgroup
CCR	Continuity of Care Record
CDA	Clinical Document Architecture
CDC	Centers for Disease Control and Prevention
CDM	Conceptual Data Model
CDT	Code on Dental Procedures and Nomenclature
CE	Client Executive
CEFACT	Centre for the Facilitation of the Administration, Commerce, and Transport
CFR	Code of Federal Regulations
CHI	Consumer Health Informatics
CIM	Common Information Model
CIO	Chief Information Officer
CM	Configuration Management
CMHS	Center for Mental Health Service
CMIA	Cash Management Improvement Act
CMM	Capability Maturity Model
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
COB	Coordination of Benefits
Conformance	Adherence to a set of regulatory, industry, or technology rules and standards
Constraints	Factors that hinder or block specific outcomes
COO	Concept of Operations
COTS	Commercial off-the-shelf
CPA	Collaboration Protocol Agreement
CPP	Collaboration Protocol Profile
CPT	Current Procedural Terminology
CRM	Customer Relationship Management
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DAIS	Data Access and Integration Service
DAML	DARPA Agent Markup Language
DARPA	Directory Access Resolution Protocol Allocation

Acronym	Definition
Dashboard	A user interface, often interactive, that organizes and presents information in a way that is easy to read.
DASIS	Drug and Alcohol Services Information System
Data model	A blueprint for building and reengineering information systems
DBMS	Database Management System
DBOR	Database of Record
DDI	Design, Development, and Implementation
DeCC	Dental Content Committee (of the ADA)
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DICOM	Digital Imaging and Communications in Medicine
DISA	Data Interchange Standards Association
DLM	Decentralized Label Model
DM	Disease Management
DME	Durable Medical Equipment
DMS	Data Management Strategy
DMTF	Distributed Management Task Force
DMZ	Demilitarized Zone
DoD	Department of Defense
DOJ	Department of Justice
Domain	A business or subject area
DRG	Diagnosis Related Group
Driver	Factors that push towards specific outcomes
DRM	Digital Rights Management
DS	Data Standards
DSMO	Designated Standard Maintenance Organization
DSS	Decision Support System; Division of State System
DST	Data Standards Table
DSTU	Draft Standard for Trial Use
DVA	Department of Veterans Affairs
E/R	Entity-relationship
E2E	End to End
EA	Enterprise Architecture
EBHR	Electronic Behavioral Health Record
ebMS	ebXML Message Service
ebXML	Electronic Business Extensible Markup Language
eCTD	Electronic Common Technical Document
EDI	Electronic Data Interchange
EDOC	Enterprise Distributed Object Computing
EEC	End Entity Certificate

Acronym	Definition
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EHRS	Electronic Health Record System
EMC	Electronic Media Claim
EMR	Electronic Medical Record
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPA	Environmental Protection Agency
E-PAL	Enterprise Privacy Authorization Language
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESB	Enterprise Service Bus
eSCM-CL	eSourcing Capability Model for Client Organization
eSCM-SP	eSourcing Capabilities Model for Service Provider
Extensibility	Ability of a software system to allow and accept significant extension of its capabilities, without major rewriting of code or changes in its basic architecture
FA	Fiscal Agent
FDA	Food and Drug Administration
FEA	Federal Enterprise Architecture
FEAF	Federal Enterprise Architecture Framework
Federated	Connected and treated as one, as in federated systems and federated databases.
FFP	Federal Financial Participation
FFS	Fee-for-Service
FHA	Federal Health Architecture
FI	Fiscal Intermediary
FIPA	Foundations of Intelligent Physical Agents
FIPS	Federal Information Processing Standards
FISMA	Federal Information Security Management Act
GGF	Global Grid Forum
GOTS	Government off-the-shelf
GPRA	Government Performance and Results Act
GSA	General Services Administration
HCBS	Home and Community-based Services
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data and Information Set
HIE	Health Information Exchange
HIMSS	Healthcare Information and Management Systems Society
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIS	Healthcare Information System
HISB	Healthcare Informatics Standards Board

Acronym	Definition
HISPC	Health Information Security and Privacy Collaborative
HIT	Health Information Technology
HITSP	Healthcare Information Technology Standards Panel
HL7	Health Level 7
HMD	Hierarchical Message Description
IA	Information Architecture
IAPD	Implementation Advance Planning Document
ICD	International Classification of Diseases
ID-FF	Identify Federation Framework
IDMS	Integrated Data Management System
IEC	International Electrotechnical Commission
IEEE	Institute of Electrical and Electronics Engineers
IETF	Internet Engineering Task Force
IHE	Integrating the Healthcare Enterprise
IHS	Indian Health Service
IM	Interaction Model
IMPI	Intelligent Platform Management Interfaces
INPC	Indiana Network for Patient Care
Interoperability	The ability of two or more systems, processes, and entities to exchange information and to use the information that has been exchanged
IPSEC	Internet Protocol Security
ISO	International Organization for Standardization
IT	Information Technology
ITIL IT	Infrastructure Library
ITU	International Telecommunications Union
IVR	Interactive Voice Response
LDM	Logical Data Model
LOB	Line of Business
LOINC	Logical Observation Identifiers, Names and Codes
Manual	A process that is not automated, normally requiring intensive use of staff time and the use of paper documents
MARS	Marketing Accounting Reporting System
MCHO	Managed Care Health Organization
MCO	Managed Care Organization
MET	Message Type
Metadata	Data about data, used to facilitate the understanding, characteristics, and management usage of data.
MH	Mental Health
MH/SA	Mental Health/Substance Abuse
MHCCM	Medicaid HIPAA-compliant Concept Model
MITA	Medicaid IT Architecture

Acronym	Definition
ML	Markup Language
MMIS	Medicaid Management Information System
MMM	MITA Maturity Model
MOF	MetaObject Facility
MOU	Memoranda of Understanding
MSIS	Medicaid Statistical Information System
MSMQ	Microsoft Message Queuing Server
MSX	Message Exchange
MTG	MITA Technical Group
NAHIT	National Alliance for Health Information Technology
NASADAD	National Association of State Alcohol and Drug Abuse Directors, Inc.
NASCIO	National Association of State Chief Information Officers
NASMD	National Association of State Medicaid Directors
NASMHPD	National Association of State Mental Health Program Directors
NCPDP	National Council for Prescription Drug Programs
NCVHS	National Committee on Vital and Health Statistics
NDC	National Drug Code
NEMA	National Electrical Manufacturers Association
NET	Non-emergency Transportation
NHII	National Health Information Infrastructure
NHIN	National Health Information Network
NIH	National Institutes of Health
NIST	National Institute of Standards and Technology
NMEH	National Medicaid EDI HIPAA (workgroup)
NOMS	National Outcome Measures
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
OAS	Office of Applied Studies, SAMHSA
OASIS	Organization for the Advancement of Structured Information Standards
OCL	Object Constraint Language
OLAP	Online Analytical Processing
OLTP	Online Transaction Processing
OM-AM	Objective, Model, Architecture, and Mechanism
OMG	Object Management Group
ONC	Office of the National Coordinator for Health IT
ONDCP	Office of National Drug Control Policy
Ontology	A formal representation of a set of concepts within an IT subject/business area and the relationships between those concepts

Acronym	Definition
OWL	Ontology Web Language
P3P	Platform for Privacy Preference Project
PBM	Pharmacy Benefit Manager
PC	Personal Computer; Proxy Certificate
PCCM	Primary Care Case Manager
PCP	Primary Care Physician
PDA	Personal Digital Assistant
Peer to Peer (P2P)	A computer network that connects nodes via largely *ad hoc* connections between participants in a network.
PHDSC	Public Health Data Standards Consortium
PHIN	Public Health Information Network
PHR	Personal Health Record
PI	Proxy Issuer
PITAC	President's Information Technology Advisory Committee
PKC	Public Key Certificate
PKI	Public Key Infrastructure
Point-to-Point	A direct connection from one location to another (point A to point B).
POS	Point-of-sale: Point-of-service
PPTP	Point-to-point Tunneling Protocol
Process interoperability	Automated integration of process activities through safe and robust record origination, retention and interchange
PS-TG	Private Sector Technology Group
QoS	Quality of Service
QRO	Quality Review Organization
QSO	Qualified Service Organization
RBAC	Role-based Access Control
RDBMS	Relational Database Management System
RDF	Reference Description Framework
RFP	Request for Proposals
RHIN	Regional Health Information Network
RHIO	Regional Health Information Organization
RIM	Reference Information Model
RMP	Remote Management Portlet
RO	Regional Office
ROI	Return on Investment
ROSC	Recovery Oriented Systems of Care
RSS	Recovery Support Services
S&P	Security and Privacy
SA	Subject Area; Substance Abuse
SAMHDA	Substance Abuse and Mental Health Data Archive

Acronym	Definition
SAMHSA	Substance Abuse and Mental Health Services Administration
SAML	Security Assertion Markup Language
SBVR	Semantics of Business Vocabulary and Rules
SCA	Service Component Architecture
SCHIP	State Children's Health Insurance Program
SDO	Standards Development Organization
SDX	State Data Exchange
Seamless	Operates smoothly across various systems and processes so that users see no differences when utilizing functions across those systems and processes
SEI	Software Engineering Institute
Semantic interoperability	Common and consistent terminology
SI	Service Infrastructure
SLA	Service Level Agreement
SLAlang	Service Level Agreement Language
SLM	Service Level Management
SME	Service Management Engine
SMHA	State Mental Health Agency
SNMP	Simple Network Management Protocol
SNOMED	Systematized Nomenclature of Medicine
SOA	Service-oriented Architecture
SOAP	Simple Object Access Protocol
SPP	Security and Privacy Profile
SQL	Structured Query Language
SRM	Standards Reference Model
SSA	Social Security Administration
SS-A	State Self-Assessment
SSC	Services Support Center
SSD	Service Structure Diagram
SSH	SecureShell
SSI	Supplemental Security Income
SSN	Social Security number
SSO	Single Sign-on
S-TAG	Systems Technical Advisory Group
SUR	Surveillance and Utilization Review
SURS	Surveillance Utilization Review System
Syntax	The grammar, structure, or order of the elements in a computer message
TA	Technical Architecture
TAL	Trust Anchor List
TANF	Temporary Assistance for Needy Families
TC	Technical Capability

Acronym	Definition
TCM	Technical Capability Matrix
Technical capability	A technical function at a specific level of maturity
Technical interoperability	Automated connectivity with tight integration of tasks, workflows, and information/record flows
TEDS	Treatment Episode Data Set
To-Be	Future state; the vision of how the business could operate in the future
TPL	Third-party Liability
TPR	Third-party Recovery
Transparent (IT)	Computer programs, procedures and changes that that the user is not aware of.
TRM	Technical Reference Model
TS	Technical Services
TSDP	Technical Service Definition Package
TSRG	Technology Standards Reference Guide
UBL	Universal Business Language
UCM	Use Case Model
UDDI	Universal Description, Discovery and Integration
UML	Unified Modeling Language
UMLS	Unified Medical Language System
UN	United Nations
URA	Unit Rebate Amount
URI	Uniform Resource Identifier
USHIK	United States Health Information Knowledgebase
VHA	Veterans Health Administration
VPN	Virtual Private Network
VRS	Voice Response System
W3C	World Wide Web Consortium
WEDI	Workgroup for Electronic Data Interchange
WFMC	Workflow Management Coalition
WFML	Workflow Management Language
WITS	Web Infrastructure for Treatment Services
WMX	Web Services for Management Extensions
WS	Web Services
WS-BPEL	Web Services for Business Process Execution Language
WS-CAF	Web Services Composite Application Framework
WSDL	Web Services Description Language
WSDM	Web Services Distribution Management
WSN	Web Services Notification
WSRF	Web Services Resource Framework
WSRM	Web Services Reliable Messaging
WSRP	Web Services Remote Portlets

Acronym	Definition
XACML	Extensible Access Control Markup Language
XAML	Extensible Application Markup Language
XDS	Cross-Enterprise Clinical Documents Sharing
XKMS	XML Key Management
XML	Extensible Markup Language
XrML	Extensible Rights Markup Language
XSL	Extensible Stylesheet Language
XSLT	XSL Transformations