Commonwealth of Virginia
Department of Medical Assistance Services

Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A)

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Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Contact: Frank Guinan
Frank.Guinan@dmas.virginia.gov
(804) 371-6453

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1.0 INTRODUCTION

This introduction provides high-level background information about the Virginia Department of Medical Assistance Services, or DMAS, and the Virginia Medicaid program. DMAS is the State Medicaid Agency (SMA) in Virginia that is responsible for managing and operating Medicaid and other public health programs.

Sections 2-7 of this document provide details on the State Self-Assessment.

1.1 DMAS Organization:

DMAS is comprised of 14 divisions and 3 offices as depicted in the organization structure chart shown below, Figure 1.1-1.

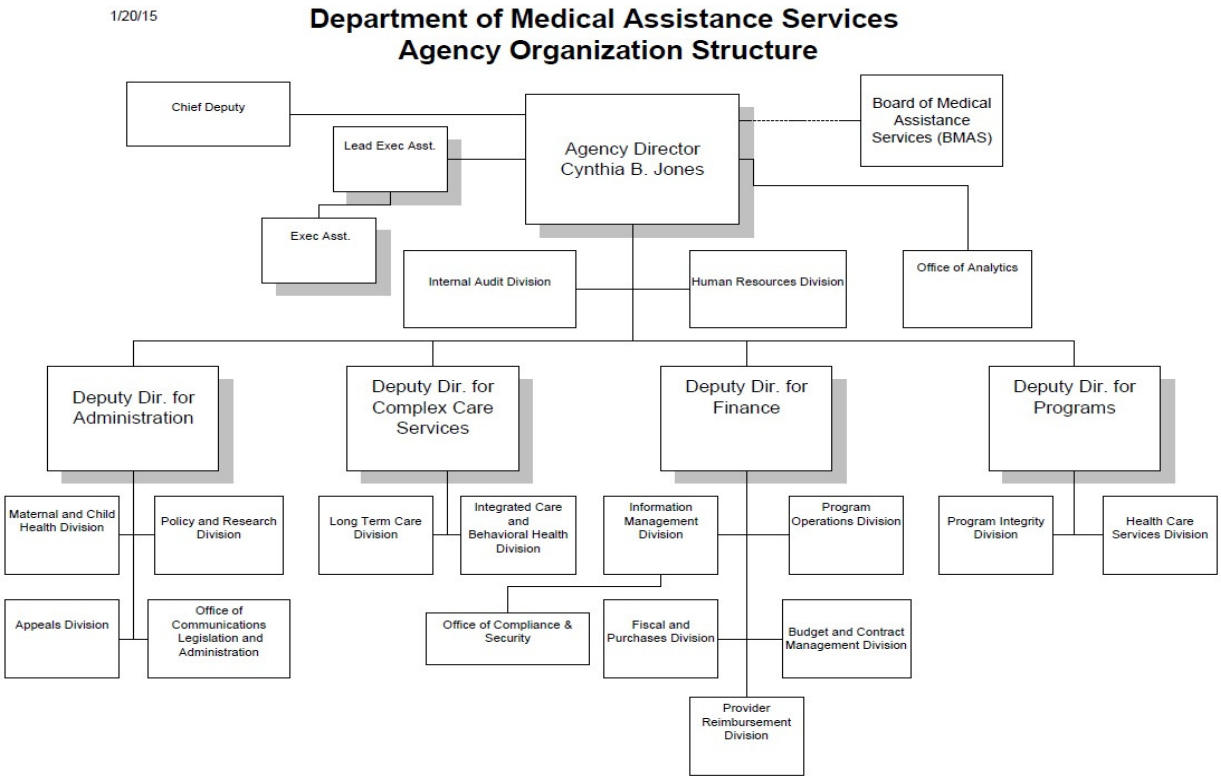


Figure 1.1-1 DMAS Organization

1.2 Overview of the Virginia Medicaid Program

In Virginia, Medicaid is administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government. Virginia's federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is generally 50%, so Virginia currently receives $1 of federal matching funds for every dollar Virginia spends on Medicaid.

Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities, and parents meeting specific income thresholds. All states must follow general federal Medicaid guidelines regarding who is covered, but states set their own income and asset eligibility criteria. Virginia's eligibility criteria are among the strictest in the nation. Figure 1.2-1 shows coverage by category.

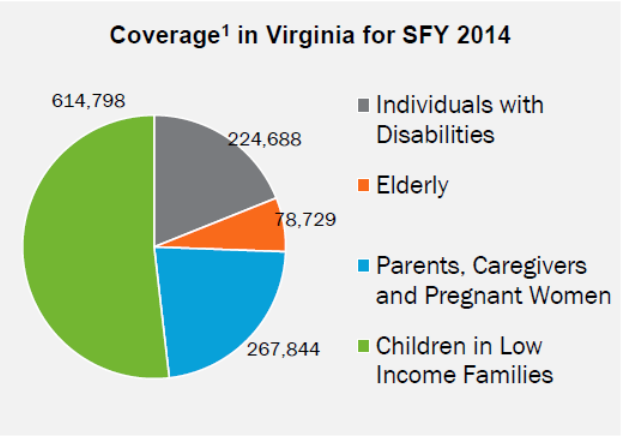


Figure 1.2-1 Coverage by Category

DMAS provides Medicaid to individuals through two delivery models: commercial managed care organizations (MCOs) and Fee for Service (direct reimbursement to service providers). Virginia has been increasing its use of the MCO program because of the value it provides to enrollees and to the Commonwealth, as shown in Figure 1.2-2.

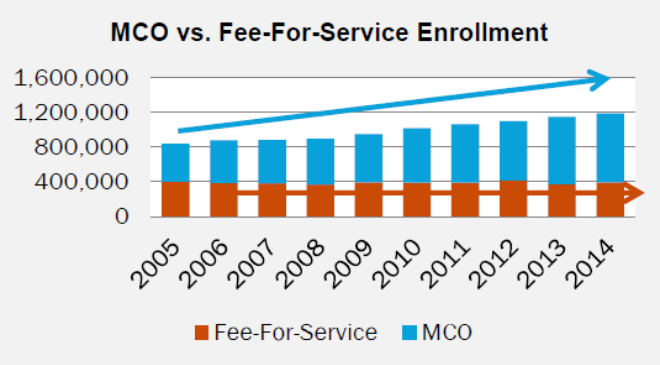


Figure 1.2-2 MCO vs. Fee-For-Service Enrollment

Virginia has focused on quality while expanding managed care. Virginia was one of the first states to require its MCOs to be accredited by the National Committee for Quality Assurance (NCQA). Accreditation is widely recognized as a commitment toward continuous quality improvement and requires MCOs to pass a rigorous, comprehensive review and report annually on performance. The benefits of accreditation impact more than half a million Virginians.

Similar to that in other states, Medicaid spending in Virginia is heavily weighted towards seniors and individuals with disabilities due to their intensive needs and use of more costly acute and long-term care services. Figure 1.2-3 shows expenditures by enrollment category.

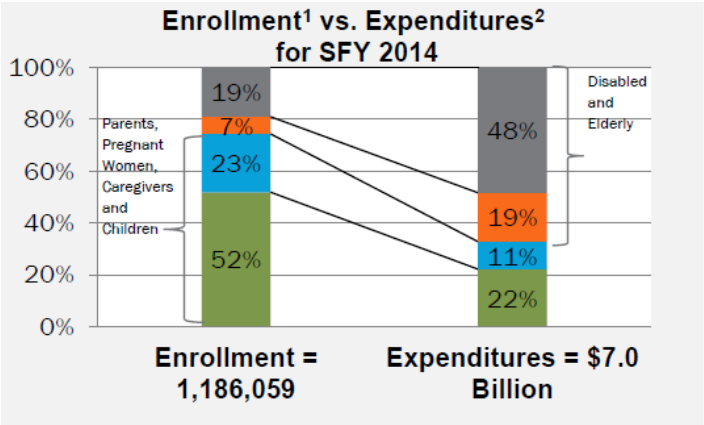


Figure 1.2-3 Expenditures by Enrollment Category

As enrollment has increased, Virginia's Medicaid expenditures have increased at a rate similar to that of other states. Virginia's spending per Medicaid enrollee consistently falls in the middle when compared to other state averages. Virginia's Medicaid spending per capita is consistently lower than that of most other states. Although increases in enrollment have been the primary driver of spending increases, other factors affecting expenditures for Medicaid in Virginia include economic changes such as health care cost inflation, advances in health care delivery, and program changes directed by federal and state law.

Enrollment in the Virginia Medicaid program continues to rise due to steady increases in enrollment numbers for all eligibility categories except for the elderly. Children's enrollment numbers are increasing fastest.

Although expenditures are rising, only 2.3% of the total FY 2014 DMAS budget was allocated toward administrative expenses.

The Virginia Medicaid program covers medical services, nursing facility services, and behavioral health services. Virginia Medicaid enrollees may also receive coverage through home and community-based "waivers." Waivers provide community-based long-term care services as an alternative to institutionalization.

Waiver programs available to Medicaid beneficiaries include:

- Alzheimer's
- Day Support for Persons with Intellectual Disabilities
- Elderly or Disabled with Consumer-Direction
- Intellectual Disabilities
- Technology Assisted
- Individual and Family Developmental Disabilities Support

DMAS continues to improve the Medicaid program in Virginia. A number of current and future initiatives are underway to address current and future challenges:

- Implementing a three-year Medicare and Medicaid enrollee (dual eligible) financial alignment demonstration
- Enhancing the quality of care and oversight for behavioral health
- Improving the coordination of service delivery for all enrollees, including recipients of long-term care services and supports

Additionally, DMAS is implementing the requirements of the Patient Protection and Affordable Care Act.

1.3 Key Vendors

DMAS divisions perform many of the operational activities for the Virginia Medicaid program. In addition, DMAS has outsourced several key functions to vendors with significant expertise in those areas. DMAS Contract Administrators are responsible for contract oversight and results measurement.

For example, Xerox serves as the Fiscal Agent for Virginia Medicaid. Xerox operates and maintains the MMIS and supplies staffing for the Help Desk. As mentioned above, DMAS is moving away from fee for service and has contracted with several Managed Care Organizations to provide Medicaid services on a capitated basis. Service Authorizations are handled by KePRO with the exception of Behavioral Health services. Magellan is the Administrative Services Organization handling fee for service behavioral health services including claims processing, Case Management, Service Authorizations and provider network management. Catamaran provides DMAS with drug-rebate management services.

2.0 EXECUTIVE OVERVIEW

In an ongoing effort for Virginia to move forward and advance the MITA vision, DMAS engaged in a MITA 3.0 State Self-Assessment (SS-A).

In 2007, DMAS conducted a baseline SS-A under MITA 1.0. In 2010, a partial SS-A was conducted that included Eligibility and Enrollment, Member Management, and Care Management. DMAS' scope in 2010 included reviewing the current strategic goals and objectives, revising the 2007 SS-A business process models and capability matrices baseline against the 2010 MITA Framework, and targeting capabilities to transform the Virginia Medicaid Enterprise to be consistent with MITA standards and principles over time. That assessment led to an Eligibility & Enrollment project that overhauled and modernized the Virginia member eligibility enrollment processes.

2.1 Objectives

Virginia is undertaking an initiative to replace the current MMIS with a modernized Medicaid Enterprise System (MES) by July 1, 2018. The MITA 3.0 SS-A is the first step in the process to assess As-Is business processes and information and technical capabilities and the To-Be business, information, and technical architectures of the future.

DMAS conducted this SS-A with the following objectives:

- Update our understanding of MITA by becoming familiar with the MITA 3.0 Framework
- Engage a wide variety of DMAS staff in the assessment process, especially at the management and supervisory levels, to provide exposure to the MITA concepts and related DMAS objectives
- Review and assess the business, information, and technical architectures in accordance with the appropriate capability matrices to document our current As-Is baseline for business processes and capability levels in all three architectures
- Use the As-Is results and identified strategic plans and objectives to perform a To-Be assessment and identify the specific capability levels that DMAS would like to achieve in the future
- Formulate the assessment findings and results to define high-level objectives that can be used to develop a Roadmap for DMAS' MITA evolution and a guide for the procurement of the Modernized Medicaid Enterprise
- Establish a library of SS-A results that can be referenced during the procurement process, for the next SS-A, and for other future initiatives as needed.

2.2 Approach

DMAS viewed the SS-A as an important step in the procurement process. The SS-A was scheduled to maximize its benefit by providing needed input in a timely manner. At the same time, it was recognized that the SS-A needed to be completed on a schedule that left enough time for the procurement process and replacement of the current MMIS. Therefore, the period of performance for the SS-A was targeted as September, 2014 through March, 2015 in support of the overall timeline shown below in Figure 2.2-1.

Big Picture Timeline

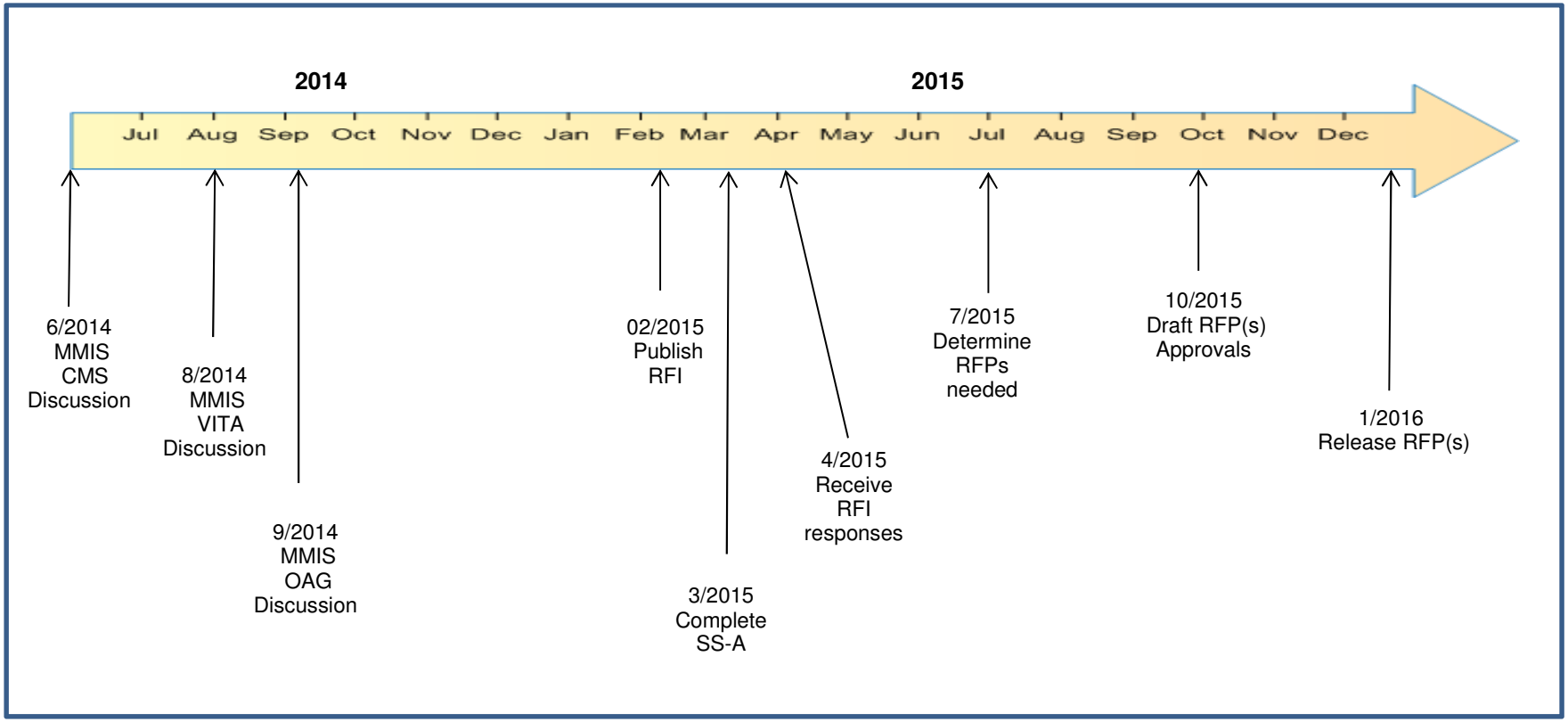


Figure 2.2-1 Overall Timeline

To accomplish the SS-A, a core project team was established. This team performed the preliminary research on the MITA 3.0 Framework and SS-A Companion Guide and defined the specific approach and activities for DMAS to follow to complete the SS-A. The core team members also reviewed he results of the previous assessments and used that information to prepare for the current SS-A.

The team focused initially on the As-Is business architecture assessment. The business areas, categories, and processes were reviewed and it was determined which DMAS staff should review and assess the business processes. To document the owners of business processes, a matrix was prepared and shared with the DMAS Division Directors for verification. The matrix appears below in Section 2.5, Business Process Owners.

The Business Architecture assessment was performed with DMAS staff, which was typically the lead and/or subject matter experts (SMEs) for each business process for the As-Is business reviews and with a smaller number of participants for the To-Be business reviews.

Meetings with the appropriate DMAS staff were scheduled. Packets were prepared of the material to be discussed, namely the business process models (BPMs) and business capability matrices (BCMs), and distributed prior to the meetings. The business process models from the MITA 3.0 Framework were discussed and annotated with DMAS differences or specific capabilities. The annotated BPMs are included in the Business Architecture assessment results in Section 3. The BCMs were also reviewed to establish the As-Is capability levels. The results are captured on the business process scorecards. The supporting information for the As-Is assessments is given as a section in the document rather than embedded in the scorecard. We found this method of documentation to be more effective and understandable.

The To-Be Business Architecture assessment was conducted with a smaller number of participants. The Directors of the DMAS operational business areas were asked either to provide To-Be capability levels and future objectives, or to review proposed information from the core team. In both cases, the To-Be assessments were reviewed and approved by directors or knowledgeable staff members. As with the As-Is assessment, the To-Be results are captured on the business process scorecards, and the supporting information for the To-Be assessments is given as a section in the document

The Information Architecture assessment was performed by the DMAS Office of Data Analytics. The Office of Data Analytics (ODA) was established in 2014. Because the current Information Architecture is immature and the ODA is just beginning its planning and developing Agency data standards, it was decided to assess the Information Architecture for the entire Agency rather than by business area. There was little to investigate or assess, since there was no documented or uniform behavior regarding data management and standards within the Agency; therefore, it was acknowledged that the capabilities for all business areas are essentially the same. The To-Be assessment was also performed by the ODA, and the results were influenced by the plans it has for overseeing the development of data standards and a data warehouse. These plans include creating an environment where there is agreement across the Agency about how data is defined and used.

The Technical Architecture assessment was performed by the Chief Solutions Architect in the Information Management Division. The current Virginia MMIS is essentially a single large system, and most business areas are supported by the MMIS. Therefore it was also decided to assess the technical architecture at the enterprise level rather than by business area. Also, we wanted to focus our attention

on the future technical direction rather than invest a significant amount of time reviewing an architecture that we believe will be virtually replaced. The Chief Solutions Architect performed both the As-Is and To-Be Technical Architecture assessments.

The Seven Standards and Conditions (7Ss&Cs) assessment was a joint effort by the core team, the Office of Data Analytics, and the Chief Solutions Architect. The 7Ss&Cs for the Business Architecture was assessed by the Lead Application Architect in the Information Division, while the same staff that performed assessment for the Information Architecture and Technical Architecture documented the 7Ss&Cs assessment for those areas.

Once completed, the Business, Information, Technical, and Seven Standards and Conditions assessment results were delivered to DMAS management for review and approval.

2.3 Findings

If an overall assessment of current capabilities were to be given to DMAS as the State Medicaid Agency, it would be a '1.5.' DMAS clearly uses a significant amount of automation, predominantly through the mainframe MMIS that supports the conventional subsystems, such as Provider, Recipient (Member), Reference, Claims Processing, etc. In addition, there are other smaller systems that are used for specialized purposes, such as Oracle Financials. This automation and other factors contribute to making the Business Architecture a solid 2 rating with several processes exceeding that in some capabilities. However, our ratings in the more technical areas, namely those related to the Information and Technical Architectures and Seven Standards and Conditions, were generally lower.

Similarly, the To-Be assessments were conducted under the assumption that DMAS would be looking to advance its capabilities in virtually every area. While the general objective would be to achieve a Level 3, this may not be achievable in the next few years for the Information Architecture and Seven Standards and Conditions. The To-Be assessment results by and large identify that we will want to investigate and pursue capability characteristics that are identified in the Level 3 descriptions in the MITA 3.0 Framework capability matrices, but where that does not seem practical, we will strive for Level 2.

Figure 2.3-1 provides an overall rating for each of the areas assessed.

Area	As-Is	To-Be
Business Architecture	2	3
Information Architecture	1	3
Technical Architecture	2	3
Seven Standards and Conditions	1	3

Figure 2.3-1 Overall Rating

A summary of the assessment results follows. The assessment details are provided in Sections 3-6 of this document, and additional summary information is in Section 7.

2.3.1 Business Architecture

Figure 2.3.1-1 provides a quantitative summary of the Business Architecture assessment. The numbers in the table represent the average capability ratings for all 75 business processes that were assessed (5 of the 80 MITA business processes were deemed to be not applicable to DMAS).

Capability	As-Is	To-Be
Accuracy of Process Results	2.15	3.01
Cost-Effectiveness	2.04	2.97
Data Access and Accuracy	2.03	2.99
Effort to Perform; Efficiency	2.05	2.99
Timeliness of Process	1.92	2.91
Utility or Value to Stakeholder	2.13	3.00

Figure 2.3.1-1 Business Architecture Assessment

2.3.2 Information Architecture

Figure 2.3.2-1 provides a summary of the Information Architecture assessment. The assessment was performed at the enterprise level.

Capability	As-Is	To-Be
Data Management	1	3
Conceptual Data Model	1	3
Logical Data Model	1	3
Data Standards	2	3

Figure 2.3.2-1 Information Architecture Assessment

2.3.3 Technical Architecture

Figure 2.2.3-1 provides a summary of the Technical Architecture assessment. The assessment was performed at the enterprise level.

Capability	As-Is	To-Be
Access and Delivery	2	3
Intermediary and Interface	1	3
Integration and Utility	2	3

Figure 2.3.3-1 Technical Architecture Assessment

2.3.4 Seven Standards and Condition

Figure 2.3.4-1 provides a summary of Seven Stands and Conditions assessment. The assessment was performed by Business Area for the Business Architecture and at the enterprise level for the Information and Technical Architectures.

Capability	BA As-Is	IA As-Is	TA As-Is	BA To-Be	IA To-Be	TA To-Be
Modularity Standard	1.3	1	1	2.1	3	3
MITA Condition	2	2	1	3	3	3
Industry Standards Condition	1.3	2	2	2	3	3
Leverage Condition	1	1	1	2	3	3
Business Results Condition	1.5	1	1	2.5	3	3
Reporting Condition	1.8	1	1	2.8	3	3
Interoperability Condition	1	1	1	2	3	3

Figure 2.3.4-1 Seven Standards and Conditions

2.4 Next Steps

DMAS is scheduled to begin a procurement process to replace the current Virginia MMIS (VAMMIS) with a Medicaid Enterprise System (MES). The contract to operate VAMMIS ends June 30, 2018.

The SS-A has exposed numerous DMAS staff to the MITA vision and framework. It has helped the Agency focus its thoughts on the current systems and operations and to begin identifying what should be changed and adopted going forward. Because one or more RFPs will be written in the near future, the To-Be vision in the SS-A was generally described as objectives that aligned with the MITA capability matrices that described Level 3 wherever that seemed to be attainable.

The information learned and results documented in the SS-A will be supplemented with the responses received from a Request for Information (RFI) that was issued in February. Responses are due by April 1. We expect the RFI responses to give further insights into options that are available and provide additional clarity to the direction DMAS will undertake when as it defines the requirements for the MES. Based on the results of the SS-A, RFI, and further analysis and discussion within the Agency, specific features and functions will be identified in the RFPs that are scheduled to be issued in January, 2016.

To help bridge the work done while developing the SS-A and beginning to write the RFPs, DMAS will document a Roadmap that transforms the objectives identified in the SS-A into a defined plan of action that is consistent with the strategic plan for DMAS, which states in part that:

> "DMAS must find innovative ways to ensure adequate provider/network access as well as strategies to bolster its own administrative capacity to handle a growing and changing client base. To be prepared, DMAS will need to monitor and act pro-actively by adjusting current activities and implementing new enhancements that provide effective and efficient services to our customers. DMAS will also need to work with Medicaid providers that must adjust to growing caseloads, stagnant or lower reimbursement rates,

and new Medicaid population groups that will seriously challenge their ability to fully absorb the financial and operational impact on their practices and businesses.

Agency priorities include the following:

- Responding to state and national Medicaid and health care reform issues;
- Coordinating care for all covered individuals and services;
- Implementing an integrated delivery model for Medicare-Medicaid enrollees;
- Improving the effectiveness of home and community-based services for seniors and people with disabilities and increase the number of Program for All Inclusive Care for the Elderly (PACE) sites;
- Increasing retention efforts to keep eligible children enrolled in Medicaid and FAMIS;
- Enhancing the Department's capabilities and operations in preventing, identifying, and eliminating fraud and abuse;
- Improving SWaM (Small, Women, and Minority) contracting and purchasing; and
- Implementing efforts to oversee and manage behavioral health services."

While this direction will be further developed through the RFI results and RFP development, some items that have been identified for further consideration thus far, which range from general to specific, include:

- Collect and integrate all fee-for-service claims in a single repository
- Address encounter processing in a manner that recognizes the variety of managed care models and programs, such as risk-based versus administrative services only (ASO)
- Enhance provider enrollment and management to address the multiple relationships providers have with DMAS and its business partners, such as managed care organizations (MCOs)
- Continue the development of the Eligibility & Enrollment (E&E) enhancement to address all members and to integrate with additional intrastate systems, such as the Commonwealth Authentication System (CAS)
- Create provider and member portals that support the 'one stop shop' objective and improve information access and service for all Medicaid related needs
- Establish and enhance exchanges with federal, State and other entities, including the Health Insurance Exchange (HIX) and Health Information Exchange (HIE)
- Identify ways to further automate and integrate business processes that were not traditionally part of an MMIS but are components of the MES, such as managing member and provider appeals and contractor management
- Collect clinical data for fee-for-service claims to better measure health outcomes and populate electronic health records (EHR)
- Develop a data warehouse that improves the breadth and quality of data available and provides the information needed to manage, operate, measure and improve the Medicaid Enterprise
- Expand the automation processes and decision making associated with business processes such as fraud detection and auditing
- Establish a technical architecture that supports the CMS and DMAS vision for current and future services and performance, including items such as an enhanced content management system that includes reports produced by our business partners and supporting a variety of user-friendly methods to access information and services in an environment that is scalable, cost-effective, and easily changed; the architecture should support innovation and experimentation.

These and other potential enhancements will be reviewed and considered with the overall objective of advancing the Virginia Medicaid Enterprise further along the MITA vision and capabilities as defined in the MITA 3.0 Framework.

2.5 Business Process Owners

A table that identifies DMAS owners of the MITA business processes follows.

MITA Business Area Title	MITA Business Category Title	MITA Business Process Title	DMAS Director	P/S	DMAS Business Owner	SME(s)	Division	DMAS Business Unit
Business Relationship Management (BR)	Standards Management	BR01 Establish Business Relationship	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Business Relationship Management (BR)	Standards Management	BR02 Manage Business Relationship Communication	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Business Relationship Management (BR)	Standards Management	BR03 Manage Business Relationship Information	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Business Relationship Management (BR)	Standards Management	BR04 Terminate Business Relationship	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Business Relationship Management (BR)	Standards Management	BR01 Establish Business Relationship	Bryan Tomlinson	S	Dan Plain	Todd Clark	Health Care Services	
Business Relationship Management (BR)	Standards Management	BR02 Manage Business Relationship Communication	Bryan Tomlinson	S	Dan Plain	Todd Clark	Health Care Services	
Business Relationship Management (BR)	Standards Management	BR03 Manage Business Relationship Information	Bryan Tomlinson	S	Dan Plain	Todd Clark	Health Care Services	
Business Relationship Management (BR)	Standards Management	BR04 Terminate Business Relationship	Bryan Tomlinson	S	Dan Plain	Todd Clark	Health Care Services	
Business Relationship Management (BR)	Standards Management	BR01 Establish Business Relationship	Peter Lubinskas	S	Darryl Hellams	Darryl Hellams	Program Ops	
Business Relationship Management (BR)	Standards Management	BR02 Manage Business Relationship Communication	Peter Lubinskas	S	Darryl Hellams	Darryl Hellams	Program Ops	
Business Relationship Management (BR)	Standards Management	BR03 Manage Business Relationship Information	Peter Lubinskas	S	Darryl Hellams	Darryl Hellams	Program Ops	
Business Relationship Management (BR)	Standards Management	BR04 Terminate Business Relationship	Peter Lubinskas	S	Darryl Hellams	Darryl Hellams	Program Ops	
Care Management (CM)	Authorization Determination	CM07 Authorize Referral	Louis Elie	P	Pat Arevalo	Patty Smith, Senthia Barlow	Program Integrity	Prior Authorization & Utilization Review
Care Management (CM)	Authorization Determination	CM07 Authorize Referral	Peter Lubinskas	S	Karen Thomas	Alyson DeSalvo, Cynthia Bosley	Program Operations	Payment processing unit
Care Management (CM)	Authorization Determination	CM07 Authorize Referral	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Care Management (CM)	Authorization Determination	CM07 Authorize Referral	Terry Smith	S	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Care Management (CM)	Authorization Determination	CM08 Authorize Service	Bryan Tomlinson	S	Donna Proffitt	Keith Hyashi, Rachel Cain	Health Care Services	Pharmacy unit
Care Management (CM)	Authorization Determination	CM08 Authorize Service	Louis Elie	P	Pat Arevalo	Patty Smith, Senthia Barlow	Program Integrity	Prior Authorization & Utilization Review
Care Management (CM)	Authorization Determination	CM08 Authorize Service	Peter Lubinskas	S	Karen Thomas	Alyson DeSalvo, Cynthia Bosley	Program Operations	Payment processing unit
Care Management (CM)	Authorization Determination	CM08 Authorize Service	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Care Management (CM)	Authorization Determination	CM08 Authorize Service	Terry Smith	S	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Care Management (CM)	Authorization Determination	CM09 Authorize Treatment Plan	Bryan Tomlinson	S	Donna Proffitt	Keith Hyashi, Rachel Cain	Health Care Services	Pharmacy unit
Care Management (CM)	Authorization Determination	CM09 Authorize Treatment Plan	Louis Elie	S	Pat Arevalo	Patty Smith, Senthia Barlow	Program Integrity	Prior Authorization & Utilization Review
Care Management (CM)	Authorization Determination	CM09 Authorize Treatment Plan	Peter Lubinskas	S	Karen Thomas	Alyson DeSalvo, Cynthia Bosley	Program Operations	Payment processing unit
Care Management (CM)	Authorization Determination	CM09 Authorize Treatment Plan	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Care Management (CM)	Authorization Determination	CM09 Authorize Treatment Plan	Terry Smith	P	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Care Management (CM)	Case Management	CM01 Establish Case	Tamara Whitlock	S	Brian Campbell		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM01 Establish Case	Tamara Whitlock	S	Matthew Behrens		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM01 Establish Case	Tamara Whitlock	S	Emily Carr		Integrated Care & Behavioral Services	CCC Program
Care Management (CM)	Case Management	CM01 Establish Case	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Care Management (CM)	Case Management	CM01 Establish Case	Terry Smith	S	Jeanette Trestrail		Long term care	Data and Quality Management
Care Management (CM)	Case Management	CM01 Establish Case	Terry Smith	S	Nichole Martin		Long term care	Program Development & Contracts
Care Management (CM)	Case Management	CM01 Establish Case	Terry Smith	P	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Care Management (CM)	Case Management	CM02 Manage Case Information	Tamara Whitlock	S	Brian Campbell		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM02 Manage Case Information	Tamara Whitlock	S	Matthew Behrens		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM02 Manage Case Information	Tamara Whitlock	S	Emily Carr		Integrated Care & Behavioral Services	CCC Program
Care Management (CM)	Case Management	CM02 Manage Case Information	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Care Management (CM)	Case Management	CM02 Manage Case Information	Terry Smith	S	Jeanette Trestrail		Long term care	Data and Quality Management
Care Management (CM)	Case Management	CM02 Manage Case Information	Terry Smith	S	Nichole Martin		Long term care	Program Development & Contracts
Care Management (CM)	Case Management	CM02 Manage Case Information	Terry Smith	P	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Care Management (CM)	Case Management	CM03 Manage Population Health Outreach	Tamara Whitlock	S	Brian Campbell		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM03 Manage Population Health Outreach	Tamara Whitlock	S	Matthew Behrens		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM03 Manage Population Health Outreach	Tamara Whitlock	S	Emily Carr		Integrated Care & Behavioral Services	CCC Program
Care Management (CM)	Case Management	CM03 Manage Population Health Outreach	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health

MITA Business Area Title	MITA Business Category Title	MITA Business Process Title	DMAS Director	P/S	DMAS Business Owner	SME(s)	Division	DMAS Business Unit
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE05 Determine Provider Eligibility	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE05 Determine Provider Eligibility	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE05 Determine Provider Eligibility	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE06 Enroll Provider	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE06 Enroll Provider	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE06 Enroll Provider	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE07 Disenroll Provider	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE07 Disenroll Provider	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE07 Disenroll Provider	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE08 Inquire Provider Information	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE08 Inquire Provider Information	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE08 Inquire Provider Information	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Financial Management (FM)	Accounts Payable Management	FM09 Manage Contractor Payment	Karen Stephenson	P	Rudy Brown	Ron Marable, Gerry Poire	Fiscal and Purchases Division	
Financial Management (FM)	Accounts Payable Management	FM09 Manage Contractor Payment	Karen Stephenson	P	Mike Harlow	Ron Marable, Gerry Poire	Fiscal and Purchases Division	
Financial Management (FM)	Accounts Payable Management	FM10 Manage Member Financial Participation	Peter Lubinskas	P	Carol Chiappa	Tiaa Lewis	Program Operations	
Financial Management (FM)	Accounts Payable Management	FM11 Manage Capitation Payment	Bryan Tomlinson	P	Donna Halbleib	Doug Hartman	Health Care Services	Pharmacy unit
Financial Management (FM)	Accounts Payable Management	FM12 Manage Incentive Payment	Seta Vandergrift	NA	Rob Chapman	Darryl Hellams	Budget and Contract Management	**No longer done at DMAS**
Financial Management (FM)	Accounts Payable Management	FM13 Manage Accounts Payable Information	Karen Stephenson	P	Mike Harlow	Ron Marable, Gerry Poire	Fiscal and Purchases Division	
Financial Management (FM)	Accounts Payable Management	FM14 Manage Accounts Payable Disbursement	Karen Stephenson	P	Mike Harlow	Ron Marable, Gerry Poire	Fiscal and Purchases Division	
Financial Management (FM)	Accounts Payable Management	FM15 Manage 1099	Peter Lubinskas	P	Darryl Hellams		Program Operations	
Financial Management (FM)	Accounts Receivable Management	FM01 Manage Provider Recoupment	Karen Stephenson	P	Rudy Brown		Fiscal and Purchases Division	
Financial Management (FM)	Accounts Receivable Management	FM02 Manage TPL Recovery	Karen Stephenson	P	Kathy Colley		Fiscal and Purchases Division	
Financial Management (FM)	Accounts Receivable Management	FM03 Manage Estate Recovery	Karen Stephenson	P	Kathy Colley		Fiscal and Purchases Division	
Financial Management (FM)	Accounts Receivable Management	FM04 Manage Drug Rebate	Bryan Tomlinson	P	Donna Proffitt	Keith Hyashi	Health Care Services	Pharmacy unit
Financial Management (FM)	Accounts Receivable Management	FM05 Manage Cost Settlement	Bill Lessard	P	Mary Hairston	Carla Russell	Provider Reimbursement	
Financial Management (FM)	Accounts Receivable Management	FM06 Manage Accounts Receivable Information	Karen Stephenson	P	Rudy Brown		Fiscal and Purchases Division	
Financial Management (FM)	Accounts Receivable Management	FM07 Manage Accounts Receivable Funds	Karen Stephenson	P	Rudy Brown		Fiscal and Purchases Division	
Financial Management (FM)	Accounts Receivable Management	FM08 Prepare Member Premium Invoice	Peter Lubinskas	P	Carol Chiappa	Tiaa Lewis	Program Operations	
Financial Management (FM)	Fiscal Management	FM16 Formulate Budget	Seta Vandergrift	P	Shionda Scott		Budget and Contract Management	
Financial Management (FM)	Fiscal Management	FM17 Manage Budget Information	Seta Vandergrift	P	Shionda Scott		Budget and Contract Management	
Financial Management (FM)	Fiscal Management	FM18 Manage Fund	Karen Stephenson	P	Brenda Cooper		Fiscal and Purchases Division	
Financial Management (FM)	Fiscal Management	FM18 Manage Fund	Seta Vandergrift	S	Shionda Scott		Budget and Contract Management	
Financial Management (FM)	Fiscal Management	FM19 Generate Financial Report	Karen Stephenson	S	Brenda Cooper		Fiscal and Purchases Division	
Financial Management (FM)	Fiscal Management	FM19 Generate Financial Report	Seta Vandergrift	P	Shionda Scott		Budget and Contract Management	
Member Management (ME)	Member Information Management	ME01 Manage Member Information	Brian McCormick	S	Cindy Olson		Policy and Research	Eligibility
Member Management (ME)	Member Information Management	ME01 Manage Member Information	Bryan Tomlinson	S	Doug Hartman	Patty Taylor	Health Care Services	Systems and Reporting
Member Management (ME)	Member Information Management	ME01 Manage Member Information	Peter Lubinskas	P	Lois Brengel		Program Operations	
Member Management (ME)	Member Support	ME02 Manage Applicant and Member Communication	Brian McCormick	S	Cindy Olson		Policy and Research	Eligibility
Member Management (ME)	Member Support	ME02 Manage Applicant and Member Communication	Bryan Tomlinson	S	Doug Hartman	Patty Taylor	Health Care Services	Systems and Reporting
Member Management (ME)	Member Support	ME02 Manage Applicant and Member Communication	Peter Lubinskas	P	Lois Brengel		Program Operations	
Member Management (ME)	Member Support	ME03 Perform Population and Member Outreach	Brian McCormick	S	Cindy Olson		Policy and Research	Eligibility
Member Management (ME)	Member Support	ME03 Perform Population and Member Outreach	Bryan Tomlinson	S	Doug Hartman	Patty Taylor	Health Care Services	Systems and Reporting
Member Management (ME)	Member Support	ME03 Perform Population and Member Outreach	Peter Lubinskas	P	Lois Brengel		Program Operations	
Member Management (ME)	Member Support	ME08 Manage Member Grievance and Appeal	Sam Metallo	P	Nolan Wilson		Appeals	Client Appeals

MITA Business Area Title	MITA Business Category Title	MITA Business Process Title	DMAS Director	P/S	DMAS Business Owner	SME(s)	Division	DMAS Business Unit
Care Management (CM)	Case Management	CM03 Manage Population Health Outreach	Terry Smith	S	Jeanette Trestrail		Long term care	Data and Quality Management
Care Management (CM)	Case Management	CM03 Manage Population Health Outreach	Terry Smith	S	Nichole Martin		Long term care	Program Development & Contracts
Care Management (CM)	Case Management	CM03 Manage Population Health Outreach	Terry Smith	P	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Care Management (CM)	Case Management	CM04 Manage Registry	Tamara Whitlock	NA	Brian Campbell		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM04 Manage Registry	Tamara Whitlock	NA	Matthew Behrens		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM04 Manage Registry	Tamara Whitlock	NA	Emily Carr		Integrated Care & Behavioral Services	CCC Program
Care Management (CM)	Case Management	CM04 Manage Registry	Tamara Whitlock	NA	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Care Management (CM)	Case Management	CM04 Manage Registry	Terry Smith	NA	Jeanette Trestrail		Long term care	Data and Quality Management
Care Management (CM)	Case Management	CM04 Manage Registry	Terry Smith	NA	Nichole Martin		Long term care	Program Development & Contracts
Care Management (CM)	Case Management	CM04 Manage Registry	Terry Smith	NA	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Care Management (CM)	Case Management	CM05 Perform Screening and Assessment	Tamara Whitlock	S	Brian Campbell		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM05 Perform Screening and Assessment	Tamara Whitlock	S	Matthew Behrens		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM05 Perform Screening and Assessment	Tamara Whitlock	S	Emily Carr		Integrated Care & Behavioral Services	CCC Program
Care Management (CM)	Case Management	CM05 Perform Screening and Assessment	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Care Management (CM)	Case Management	CM05 Perform Screening and Assessment	Terry Smith	S	Jeanette Trestrail		Long term care	Data and Quality Management
Care Management (CM)	Case Management	CM05 Perform Screening and Assessment	Terry Smith	S	Nichole Martin		Long term care	Program Development & Contracts
Care Management (CM)	Case Management	CM05 Perform Screening and Assessment	Terry Smith	P	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Care Management (CM)	Case Management	CM06 Manage Treatment Plan and Outcomes	Tamara Whitlock	S	Brian Campbell		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM06 Manage Treatment Plan and Outcomes	Tamara Whitlock	S	Matthew Behrens		Integrated Care & Behavioral Services	Policy
Care Management (CM)	Case Management	CM06 Manage Treatment Plan and Outcomes	Tamara Whitlock	S	Emily Carr		Integrated Care & Behavioral Services	CCC Program
Care Management (CM)	Case Management	CM06 Manage Treatment Plan and Outcomes	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Care Management (CM)	Case Management	CM06 Manage Treatment Plan and Outcomes	Terry Smith	S	Jeanette Trestrail		Long term care	Data and Quality Management
Care Management (CM)	Case Management	CM06 Manage Treatment Plan and Outcomes	Terry Smith	S	Nichole Martin		Long term care	Program Development & Contracts
Care Management (CM)	Case Management	CM06 Manage Treatment Plan and Outcomes	Terry Smith	P	Stephen Ankiel	Melissa Fritzman	Long term care	Aging Services, Tech Waiver & PACE
Contractor Management (CO)	Contract Management	CO05 Produce Solicitation	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Contractor Management (CO)	Contract Management	CO06 Award Contract	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Contractor Management (CO)	Contract Management	CO07 Manage Contract	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Contractor Management (CO)	Contract Management	CO08 Close Out Contract	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Contractor Management (CO)	Contractor Information Management	CO01 Manage Contractor Information	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Contractor Management (CO)	Contractor Information Management	CO04 Inquire Contractor Information	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Contractor Management (CO)	Contractor Support	CO02 Manage Contractor Communication	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Contractor Management (CO)	Contractor Support	CO03 Perform Contractor Outreach	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Contractor Management (CO)	Contractor Support	CO09 Manage Contractor Grievance and Appeal	Seta Vandergrift	P	Tanyea Amos	Chris Banaszak, Linda Struck	Budget and Contract Management	Contract Management Unit
Eligibility and Enrollment Management (EE)	Member Enrollment	EE01 Determine Member Eligibility	Brian McCormick	S	Cindy Olson		Policy and Research	Eligibility
Eligibility and Enrollment Management (EE)	Member Enrollment	EE01 Determine Member Eligibility	Bryan Tomlinson	S	Doug Hartman	Patty Taylor	Health Care Services	Systems and Reporting
Eligibility and Enrollment Management (EE)	Member Enrollment	EE01 Determine Member Eligibility	Peter Lubinskas	P	Lois Brengel		Program Operations	
Eligibility and Enrollment Management (EE)	Member Enrollment	EE02 Enroll Member	Brian McCormick	S	Cindy Olson		Policy and Research	Eligibility
Eligibility and Enrollment Management (EE)	Member Enrollment	EE02 Enroll Member	Bryan Tomlinson	S	Doug Hartman	Patty Taylor	Health Care Services	Systems and Reporting
Eligibility and Enrollment Management (EE)	Member Enrollment	EE02 Enroll Member	Peter Lubinskas	P	Lois Brengel		Program Operations	
Eligibility and Enrollment Management (EE)	Member Enrollment	EE03 Disenroll Member	Brian McCormick	S	Cindy Olson		Policy and Research	Eligibility
Eligibility and Enrollment Management (EE)	Member Enrollment	EE03 Disenroll Member	Bryan Tomlinson	S	Doug Hartman	Patty Taylor	Health Care Services	Systems and Reporting
Eligibility and Enrollment Management (EE)	Member Enrollment	EE03 Disenroll Member	Peter Lubinskas	P	Lois Brengel		Program Operations	
Eligibility and Enrollment Management (EE)	Member Enrollment	EE04 Inquire Member Eligibility	Brian McCormick	S	Cindy Olson		Policy and Research	Eligibility
Eligibility and Enrollment Management (EE)	Member Enrollment	EE04 Inquire Member Eligibility	Bryan Tomlinson	S	Doug Hartman	Patty Taylor	Health Care Services	Systems and Reporting
Eligibility and Enrollment Management (EE)	Member Enrollment	EE04 Inquire Member Eligibility	Peter Lubinskas	P	Lois Brengel		Program Operations	
Eligibility and Enrollment Management (EE)	Provider Enrollment	EE05 Determine Provider Eligibility	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting

MITA Business Area Title	MITA Business Category Title	MITA Business Process Title	DMAS Director	P/S	DMAS Business Owner	SME(s)	Division	DMAS Business Unit
Operations Management (OM)	Claims Adjudication	OM04 Submit Electronic Attachment	Peter Lubinskas	P	Karen Thomas	Alyson DeSalvo, Cynthia Bosley,	Program Operations	Payment processing unit
Operations Management (OM)	Claims Adjudication	OM05 Apply Mass Adjustment	Peter Lubinskas	P	Karen Thomas	Alyson DeSalvo, Cynthia Bosley,	Program Operations	Payment processing unit
Operations Management (OM)	Claims Adjudication	OM07 Process Claims	Peter Lubinskas	P	Karen Thomas	Alyson DeSalvo, Cynthia Bosley,	Program Operations	Payment processing unit
Operations Management (OM)	Claims Adjudication	OM20 Calculate Spend-Down Amount	NA	NA				This is done at DSS as a pre-req to enrollment
Operations Management (OM)	Claims Adjudication	OM29 Process Encounters	Bryan Tomlinson	P	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Operations Management (OM)	Claims Adjudication	OM29 Process Encounters	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Operations Management (OM)	Claims Adjudication	OM29 Process Encounters	Peter Lubinskas	P	Bill Zieser	Bob Knox	Program Operations	Transportation Services
Operations Management (OM)	Payment and Reporting	OM14 Generate Remittance Advice	Peter Lubinskas	P	Karen Thomas	Eileen Miller, Alyson DeSalvo	Program Operations	
Operations Management (OM)	Payment and Reporting	OM18 Inquire Payment Status	Peter Lubinskas	P	Karen Thomas	Eileen Miller, Alyson DeSalvo	Program Operations	
Operations Management (OM)	Payment and Reporting	OM27 Prepare Provider Payment	Bryan Tomlinson	S	Donna Halbleib	Doug Hartman	Health Care Services	Pharmacy unit
Operations Management (OM)	Payment and Reporting	OM27 Prepare Provider Payment	Peter Lubinskas	P	Karen Thomas	Eileen Miller	Program Operations	
Operations Management (OM)	Payment and Reporting	OM27 Prepare Provider Payment	Terry Smith	P	Melissa Fritzman		Long term care	
Operations Management (OM)	Payment and Reporting	OM28 Manage Data	Bhaskar Mukherjee	S	James Starkey	Doug Hartman	Data Analytics	
Operations Management (OM)	Payment and Reporting	OM28 Manage Data	Mukundan Srinivasan	P	Jim Rogers	Bob Wiesner	Information Management	
Perfomance Management (PE)	Compliance Management	PE01 Identify Utilization Anomalies	Louis Elie	P	Carol Cartte		Program Integrity	Provider Review
Perfomance Management (PE)	Compliance Management	PE01 Identify Utilization Anomalies	Louis Elie	P	Yolanda Hardy		Program Integrity	Recipient Audit
Perfomance Management (PE)	Compliance Management	PE02 Establish Compliance Incident	Louis Elie	P	Carol Cartte		Program Integrity	Provider Review
Perfomance Management (PE)	Compliance Management	PE02 Establish Compliance Incident	Louis Elie	P	Yolanda Hardy		Program Integrity	Recipient Audit
Perfomance Management (PE)	Compliance Management	PE03 Manage Compliance Incident Information	Louis Elie	P	Carol Cartte		Program Integrity	Provider Review
Perfomance Management (PE)	Compliance Management	PE03 Manage Compliance Incident Information	Louis Elie	P	Yolanda Hardy		Program Integrity	Recipient Audit
Perfomance Management (PE)	Compliance Management	PE04 Determine Adverse Action Incident	Louis Elie	P	Carol Cartte		Program Integrity	Provider Review
Perfomance Management (PE)	Compliance Management	PE04 Determine Adverse Action Incident	Louis Elie	P	Yolanda Hardy		Program Integrity	Recipient Audit
Perfomance Management (PE)	Compliance Management	PE05 Prepare REOMB	Louis Elie	P	Carol Cartte		Program Integrity	Provider Review
Plan Management (PL)	Health Benefits Administration	PL06 Manage Health Benefit Information	Brian McCormick	P	Paula Margolis		Policy and Research	Policy and Program Development
Plan Management (PL)	Health Benefits Administration	PL06 Manage Health Benefit Information	Peter Lubinskas	S	Karen Thomas	Eileen Miller	Program Operations	Payment processing unit
Plan Management (PL)	Health Benefits Administration	PL07 Manage Reference Information	Bryan Tomlinson	S	Donna Proffitt		Health Care Services	Pharmacy unit
Plan Management (PL)	Health Benefits Administration	PL07 Manage Reference Information	Peter Lubinskas	P	Karen Thomas	Eileen Miller	Program Operations	Payment processing unit
Plan Management (PL)	Health Benefits Administration	PL08 Manage Rate Setting	Bill Lessard	P	Carla Russell		Provider Reimbursement	Acute care rate setting unit
Plan Management (PL)	Health Benefits Administration	PL08 Manage Rate Setting	Bill Lessard	S	Nick Mercier		Provider Reimbursement	LTC rate setting/revenue maximization unit
Plan Management (PL)	Health Plan Administration	PL04 Manage Health Plan Information	Brian McCormick	P	Paula Margolis		Policy and Research	Policy and Program Development
Plan Management (PL)	Health Plan Administration	PL05 Manage Performance Measures	Brian McCormick	P	Paula Margolis		Policy and Research	Policy and Program Development
Plan Management (PL)	Health Plan Administration	PL05 Manage Performance Measures	Seta Vandergrift	S	David Stankavich		Policy and Research	Policy and Program Development
Plan Management (PL)	Plan Administration	PL01 Develop Agency Goals and Objectives	Brian McCormick	P	Paula Margolis		Policy and Research	Policy and Program Development
Plan Management (PL)	Plan Administration	PL02 Maintain Program Policy	Brian McCormick	P	Paula Margolis		Policy and Research	Policy and Program Development
Plan Management (PL)	Plan Administration	PL03 Maintain State Plan	Brian McCormick	P	Paula Margolis		Policy and Research	Eligibility

MITA Business Area Title	MITA Business Category Title	MITA Business Process Title	DMAS Director	P/S	DMAS Business Owner	SME(s)	Division	DMAS Business Unit
Provider Management (PM)	Provider Information Management	PM01 Manage Provider Information	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Provider Management (PM)	Provider Information Management	PM01 Manage Provider Information	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Provider Management (PM)	Provider Information Management	PM01 Manage Provider Information	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Provider Management (PM)	Provider Information Management	PM08 Terminate Provider	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Provider Management (PM)	Provider Information Management	PM08 Terminate Provider	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Provider Management (PM)	Provider Information Management	PM08 Terminate Provider	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Provider Management (PM)	Provider Support	PM02 Manage Provider Communication	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Provider Management (PM)	Provider Support	PM02 Manage Provider Communication	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Provider Management (PM)	Provider Support	PM02 Manage Provider Communication	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Provider Management (PM)	Provider Support	PM03 Perform Provider Outreach	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Provider Management (PM)	Provider Support	PM03 Perform Provider Outreach	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Provider Management (PM)	Provider Support	PM03 Perform Provider Outreach	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health
Provider Management (PM)	Provider Support	PM07 Manage Provider Grievance and Appeal	Bryan Tomlinson	S	Doug Hartman	Donna Halbleib	Health Care Services	Systems and Reporting
Provider Management (PM)	Provider Support	PM07 Manage Provider Grievance and Appeal	Peter Lubinskas	P	Cynthia Cors	Darryl Hellams	Program Operations	Customer Services Unit
Provider Management (PM)	Provider Support	PM07 Manage Provider Grievance and Appeal	Sam Metallo	S	Jane Nunn		Appeals	Provider Appeals
Provider Management (PM)	Provider Support	PM07 Manage Provider Grievance and Appeal	Tamara Whitlock	S	Sandra Brown	Jill Gambosh	Integrated Care & Behavioral Services	Behavioral Health

3.0 BUSINESS ARCHITECTURE ASSESSMENT

The Business Architecture SS-A defines state As-Is business operations and develops the targeted To-Be environment of the enterprise with defined business capabilities and performance standards. The assessment was performed for all of the business processes in the ten business areas defined in the MITA 3.0 Framework using the business process models (BPMs) and business capability matrices (BCMs). It was determined that 5 of the 80 MITA-defined business processes do not apply to DMAS.

The results of the business architecture assessment for each of the ten business areas are contained in the following sections. The business areas are defined in Figure 3.0-1 below.

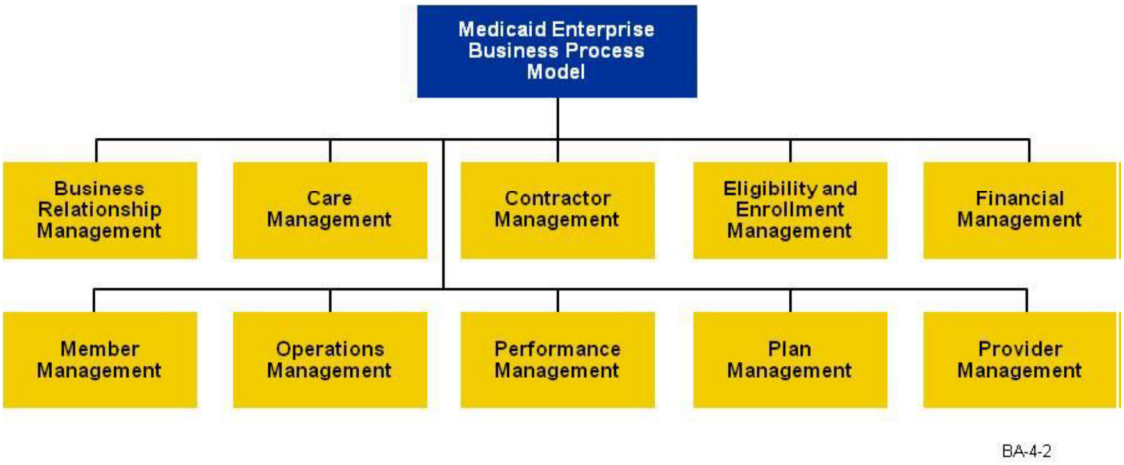


Figure 3.0-1

3.1 BUSINESS RELATIONSHIP MANAGEMENT

OVERVIEW

The Business Relationship Management business area is a collection of business processes that facilitates the coordination of standards of interoperability. This business area defines the exchange of information and Trading Partner Agreements (TPA) between the SMA and its partners, including collaboration among intrastate agencies, interstate agencies, and federal agencies. These agreements contain functionality for interoperability, establishment of inter-agency Service Level Agreements (SLA), identification of the types of information exchanged, and security and privacy requirements. The Business Relationship Management business area has a common focus (e.g., data exchange standards and SLA) and is responsible for the business relationship data store.

The Business Relationship Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.1-1.

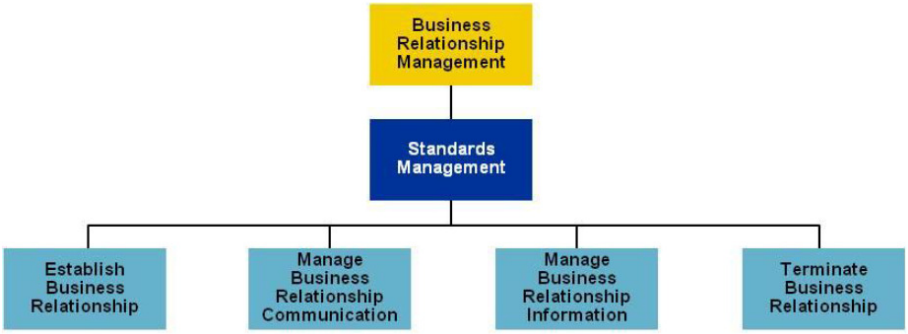


Figure 3.1-1

BUSINESS ARCHITECTURE PROFILE

The Business Relationship Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Business Relationship Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Establish Business Relationship		As-Is	To-Be		
Manage Business Relationship Communication		As-Is	To-Be		
Manage Business Relationship Information		As-Is	To-Be		
Terminate Business Relationship		As-Is	To-Be		

3.1.1 Standards Management

As shown in Figure 3.1-1, the Standards Management business category is made up of 4 business processes:

- Establish Business Relationship
- Manage Business Relationship Communication
- Manage Business Relationship Information
- Terminate Business Relationship

Details regarding the assessment of each Standards Management business process follow.

3.1.1.1 Establish Business Relationship

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Establish Business Relationship business process.

3.1.1.1.1 Business Process Model

The Establish Business Relationship business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

BR Standards Management		
Establish Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Establish Business Relationship*** business process encompasses activities undertaken by the State Medicaid Agency (SMA) to enter into business partner relationships. Agreements are between state agency and its partners, including collaboration amongst intrastate agencies, the interstate and federal agencies. It contains functionality for interoperability, establishment of inter-agency service agreements, identification of the types of information exchanged, and security and privacy requirements. These include Trading Partner Agreements (TPA), Service Level Agreements (SLA), and Memoranda of Understanding (MOU) with other agencies; Electronic Data Interchange (EDI) agreements with providers, Managed Care Organizations (MCOs), and others; and Centers for Medicare & Medicaid Services (CMS), other federal agencies, and Regional Health Information	IAG is what we call MOUs for the Inter-agency service agreements is the only one applicable to Chris and Linda's area. Omnibus agreements is another type of IAG, but larger, more services. They are used for scenarios where we have multiple divisions at DMAS who have a business agreement with another state agency. (VDH, DBHDS, DSS, and DARS, VCU) Business Associate Agreement, another attachment to the contract/IAG as appropriate to establish proper handling of PHI. When we have a contract, these

BR Standards Management		
Establish Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
	Organizations (RHIO).	elements are a part of the contract, not separate agreements. Provider: Virginia Health Quality Center (VHQC) is our RHIO in Virginia Managed Care: External Quality Review Org is DelMarva transitioning to Health Services Advisory Group (HSAG) as of 2/1/2015
Trigger Event	Environment-based Trigger Events to include but not limited to: • Request made for business relationship (e.g., EDI, email, mail, facsimile, telephone). • Identification of the need for a business relationship (e.g., new policy, new program). •	The triggers are typically initiated by the contract administrators, IAG administrator. No additional comments for Managed Care Plans and Providers
Result	• The SMA agrees upon Business Relationship with business partner. • Defined communication protocols for data exchange. • Alert to send notification to business partner of agreement. • Established agreement between business partners (e.g., TPA, SLA, MOU). • Tracking information as needed for measuring performance and business activity monitoring.	At DMAS we call MOU an IAG. Budget and Contract Management (BCM) trains the contract & IAG administrators how to write performance measurements, and provide feedback to improve measurements. For Managed Care Plans and ASOs we don't have an MOU or an IAG we would instead have a contract.
Business Process Steps	1. **START:** Receive request for business relationship from partner. 2. Conduct collection of agreement	These process steps are jointly shared with the contract and IAG administrators and BCM (Budget and Contract Management).

BR Standards Management		
Establish Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
	information with other party. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor completes all required fields. 4. Validate that the provided information is authentic. 5. Decide determination for establishment of relationship. If no agreement, go to step 9. 6. Establish terms of the business relationship (e.g., TPA, SLA, MOU). 7. Establish Key Performance Indicator (KPI). 8. Establish payment agreements. 9. Establish data exchange requirements. 10. Establish authentication protocol. 11. Establish security protocol. 12. Establish privacy requirements. 13. Agreement on business relationship. 14. **END:** Send alert to notify business partner of agreement.	BCM does step 8 (develop and /or review the payment terms) BCM gives feedback on 7 BCM involved in #12 (in the Business Associate Agreements) The contract and IAG administrators perform the other steps. We think that step 5 is always going to occur at DMAS, never skip to step 9. We use SLAs for Myers and Stauffers, CGI, Xerox, and Logisticare, We use KPIs for MCOs and we use SLAs for the Enrollment Broker (currently Maximus). Xerox serves as our EDI administrator for the HIPAA transactions coming in and going out. Establishment of a Business Associate Agreement (BAA) is part of our business process.
Shared Data	Business Partner data store including service agreement information Contractor data store including contract information	Data stores are maintained at the program level. BCM maintains original files on the J drive for every agreement and hard-copies. This does not include MCO and Provider Agreements maintained

BR Standards Management		
Establish Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
		outside of BCM. For providers the data store is housed in ECM by Xerox. For Managed Care Plans the service agreements are maintained in a combination electronic files that are then downloaded into spreadsheets, paper files. We use FTP sites to exchange data between the plans and DMAS, e.g. reporting that we are required to exchange on a monthly/quarterly basis, eligibility, payment information, adhoc reporting, compliance reports, newborn reports, death information.
Predecessor	**Receive Inbound Transaction** ***Award Contract*** ***Enroll Provider*** ***Maintain Program Policy*** ***Maintain State Plan***	
Successor	**Send Outbound Transaction** ***Manage Business Relationship Information*** ***Manage Business Relationship Communication***	
Constraints	Federal and state policies and regulations will constrain these agreements.	Budget is another constraint. Legal actions that are pending against a MCO plan or provider. Providers have to meet all ACA Enrollment requirements.
Failures	• Parties are unable to agree on terms of relationship.	We have cancelled RFPs due to insufficient qualified vendors. Provider does not meet enrollment criteria. MCO Plan is not able to meet contract requirements due to our

BR Standards Management		
Establish Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
		standards for their provider networks. Lack of business need in a particular region.
Performance Measures	• Time to complete business process = within days • Accuracy with which edits are applied =_____ • Consistency of decisions and disposition =____ • Error rate = __% or less	MCO Plans Standards and Measurements are Documented in the Contracts as follows: • Timeliness for claims processing • Appeals standards • Abandonment rates, average speed of answer • Average call handle time • Reporting submission standards • Authorization standard • Enrollment Broker, the standards are documented in the RFP. Before we sign the contract with a new MCO we have a quality review on-site, with the EQRO. Accuracy is not really measured. We strive for 100% but realize that human error may occur. Consistency is 100%, and Error Rate is not measured. Providers: Provider Enrollment Contractor (Xerox) has to complete enrolling a provider within 10 business days. For Vendors, the standards and performance measures are documented in their contracts. Accuracy is not really measured. We strive for 100% but realize that human error may occur, Consistency is 100%, and Error Rate is not measured. Time to complete: variable depending on the complexity of the

BR Standards Management		
Establish Business Relationship		
Item	Details	DMAS Differences/Comments
		agreement. Typically it would be completed within 3 to 18 months. Accuracy: 100% accuracy, Contract administrators and IAG administrator may perform periodic reviews for needed updates. Consistency of decisions: Not Applicable Error Rate: zero %.

3.1.1.1.2 As-Is Assessment

The overall rating for the Establish Business Relationship business process is '2.' This business area encompassed several types of business relationships such as Providers, Vendors, Managed Care Plans, other state agencies such as Department of Social Services, federal agencies such as CMS and Social Security Administration. DMAS uses several types of agreements to enforce the expectations for business relationships for example Service Level Agreements (SLA), Inter-agency Agreements (IAG), Contracts, Business Associate Agreements (BAA), and Trading Partner Agreements (TPA). The capability levels for Managed Care Plans (MCO) and Providers trended at a Level 2, but the business relationships handled by the Budget and Contracts division trended a bit higher at 3 in some instances due to extensive use of standardized agreements and templates. MCO Plans Standards and Measurements are documented in contracts. Before a contract is signed with a new MCO, an on-site quality review is conducted.

Other items noted in the As-Is assessment were:

- DMAS uses state-wide Omnibus Agreements
- Data stores are maintained in several different places by program.
- Provider enrollment must be completed by the provider enrollment contractor within 10 days
- The time to enroll Managed Care Plans and some of the other business partners varies and is not tracked as a metric.

3.1.1.1.3 To-Be Assessment

DMAS intends to achieve Level 3 for the Establish Business Relationship business process.

Specific objectives include:

- Development of standardized metrics that are relevant to each business unit to measure timeliness, accuracy, consistency, error rates, and stakeholder satisfaction

- Expanded use of the online portal to additional types of trading partners
- Increased automation of trading partner agreements
- Use of State and National information hubs when relevant to the business area

These objectives will result in greater consistency of process across business areas, improved tracking of trading partner performance, and better data available for decision making.

3.1.1.1.4 Scorecard

The following scorecard was compiled for the Establish Business Relationship business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
BR Standards Management Establish Business Relationship	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		

Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.1.1.2 Manage Business Relationship Communication

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Business Relationship Communication business process.

3.1.1.2.1 Business Process Model

The Manage Business Relationship Communication business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

BR Standards Management		
Manage Business Relationship Communication		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Business Relationship Communication*** business process receives requests for information, appointments, and assistance from business partners, such as inquiries related to a Service Level Agreement (SLA). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages. Information communicated by a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI).	
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive requests from other business processes to develop and produce communications for business partners such as alerts from ***Establish Business Relationship*** business process. • Receive inquiries originating	These are not relevant to Budget and Contract Maintenance (BCM), these are relevant to the Contract and IAG administrators.

BR Standards Management		
Manage Business Relationship Communication		
Item	**Details**	**DMAS Differences/Comments**
	from customer help desk through ***Manage Business Relationship Information*** business process. Environment-based Trigger Events to include but not limited to: • Receive inquiry from business partner. • Request to send information packages such as a SLA or a Key Performance Indicator (KPI). • Receive request for assistance, such as a request for training or change in business partner information. • Periodic timetable (e.g., monthly) is due for sending information (e.g., within 24 hours of new business partner agreement and periodic communications such as newsletters or other agency communications).	
Result	• Business partner receives appropriate assistance, communication, and/or information packages. • Tracking information as needed for measuring performance and business activity monitoring.	Blast emails: We track bounced email addresses, emails that ended up in spam folders, delivered, we can tell how many people opened the email. Mailings: we track returned mail, try to resolve with correct address, approximately 20,000 pieces of returned mail for providers and MCOs.
Business Process Steps	1. **START:** Receive request for communication.	Step 1: we frequently initiate a communication The divisions within

BR Standards Management		
Manage Business Relationship Communication		
Item	**Details**	**DMAS Differences/Comments**
	2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. 4. Agency logs request for communication. 5. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web, or Electronic Data Interchange (EDI)). 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).	DMAS will often request that a communication go out to the Plans and Providers. Step 2: USPS Postal software is used to validate format of addresses and to perform the pre-sort for the mailing. Step 4: Program Ops retains a record of what was sent out, but not necessarily the specific addresses that it went to. Can specify recipients of the communication based on criteria. We use the address information on file at the time of the mailing. Step 6: We have the capability to send materials out in English and/or Spanish but do not have a current business need to send out Spanish materials to our trading partners. Step 10: We do track the success of the mailing vs. returned/rejected mail. We do track customer satisfaction via surveys. We do not track first time resolution rate.
Shared Data	Business Partner data store including service agreements information Contractor data store including contract information	Business Partner data store includes VAMMIS provider database, K drive, Provider Portal communications stored

BR Standards Management		
Manage Business Relationship Communication		
Item	**Details**	**DMAS Differences/Comments**
		on ECM. Provider workgroup listserv.
Predecessor	**Receive Inbound Transaction** ***Establish Business Relationship*** ***Manage Business Relationship Information*** ***Terminate Business Relationship*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information***	
Successor	**Send Outbound Transaction** ***Manage Performance Measures***	Manage Business Relationship Information business process
Constraints	The State Medicaid Agency (SMA) and its business partners agree on the content of the communications. Content depends on the business relationship. Content may be standards-based. Communication complies with federal and state regulations that may vary by state. Business partner may have communication barriers such as lack of internet or phone access. Business partner is unable to access needed or requested information.	Phone access is the only one of these constraints that we do not experience. We mitigate the impact of lack of internet by sending communications by mail if needed.
Failures	• The SMA is unable to provide linguistically, culturally, or competency appropriate information. • Delivery failures due to erroneous contact information or lack of contact information.	DMAS does not communicate any differently with providers based on the populations that they treat. We have the ability to communicate in English or Spanish, but currently communicate with providers and plans exclusively in English.

BR Standards Management		
Manage Business Relationship Communication		
Item	**Details**	**DMAS Differences/Comments**
Performance Measures	• Time to complete response: By phone ___minutes; by email ___hours; by mail___ days • Accuracy of communications = ___% • Communications successfully delivered = ___%	Time to Complete: Variable Commonwealth Martin mailing vendor that we use for Provider mailings must have our mailings out the door within 5 days of receipt. Accuracy: 100% Communications successfully delivered: More relevant to providers than other types of business partners. Percentage of communications successfully delivered is not tracked.

3.1.1.2.2 As-Is Assessment

The overall rating for the Manage Business Relationship Communication business process is '2.' DMAS uses its state Medicaid website, provider portal, remittance notices, email blasts and mass mailings to communicate with its trading partners. Important communications such as Medicaid Memos describing changes to billing practices, Medicaid policy and/or system changes are posted on the provider portal and also mailed to providers via the US Postal Service mail service. DMAS uses a mailing vendor for its mass mailings.

Other items noted in the As-Is assessment were:

- Business Units including the Interagency Administrators and Contract Administrators frequently initiate communication to Providers, MCO Plans, and Vendors.
- Program Operations has the capability to specify recipients of the communication based on automated criteria.
- DMAS uses USPS Postal software to validate format of addresses and to perform the pre-sort for the mailing.
- DMAS attempts to get a corrected address for undeliverable mail but does not track the percent delivered successfully.

- Email addresses continue to be a challenge, not a required field.
- DMAS has the capability to send materials in English or Spanish however there is not a current business need to send materials in Spanish.
- Surveys are used to track customer satisfaction however we do not track first time resolution rate.
- We mitigate the impact of lack of internet by sending communications by mail if needed.
- The mailing vendor must send out DMAS mass mailings within 5 days of receipt.

3.1.1.2.3 To-Be Assessment

DMAS intends to achieve Level 3 for the Manage Business Relationship Communication business process.

Specific objectives include:

- Development of standardized metrics that are relevant to each business unit to measure timeliness, accuracy, consistency, error rates, and stakeholder satisfaction, such as,
    - Track the percentage of communications not delivered successfully
    - Track first time resolution rate of help desk calls
- Perform periodic outreach to correct undeliverable addresses
- Actively promote the use of the DMAS web portal for communication
- Expand use of the DMAS web portal to additional types of trading partners
- Increase focus on the reliability of email addresses

Completion of these objectives will result in more reliable communication methods and will reduce cost of communications over time.

3.1.1.2.4 Scorecard

The following scorecard was compiled for the Manage Business Relationship Communication business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
BR Standards Management ***Manage Business Relationship Communication***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3

Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.1.1.3 Manage Business Relationship Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Business Relationship Information business process.

3.1.1.3.1 Business Process Model

The Manage Business Relationship Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

BR Standards Management

Manage Business Relationship Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Business Relationship Information*** business process maintains the agreement between the State Medicaid Agency (SMA) and the other party such as the intrastate, interstate, and federal agencies. This includes routine modifications to required information such as authorized signers, addresses, terms of agreement, Key Performance Indicator (KPI), and data exchange standards.	This business process is also relevant to contracts.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive agreement modifications (e.g., create, update, or delete).	
Result	• Modified business relationship agreement. • Alert to send notification to business partner of agreement. • Tracking information as needed for measuring performance and business activity monitoring.	Tracking information-handled by contract and IAG administrators.
Business Process Steps	1. **START:** Receive agreement updates. 2. Agency logs request for modification. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 4. Validate that the provided information is authentic. 5. Staff records modification to business relationship agreement. 6. **END:** Send alert to notify business partner of modification.	We also review and update agreements based on a due date.
Shared Data	Business Partner data store including service	EDI Trading Partners agreements are

BR Standards Management		
Manage Business Relationship Information		
Item	**Details**	**DMAS Differences/Comments**
	agreement information Contractor data store including contract information	scanned and stored in ECM in addition to retaining the signed documents.
Predecessor	***Establish Business Relationship*** ***Manage Contract***	***Terminate Business Relationship*** ***Manage Business Relationship Communication*** ***RFP Award***
Successor	**Send Outbound Transaction** ***Manage Business Relationship Communication*** ***Terminate Business Relationship***	Manage Business Relationship Communication is shared between BCM and Contract/IAG administrators
Constraints	Modifications include all information in the agreement, and depend on the type of agreement and service level requirements associated with the agreement.	
Failures	• Information does not comply with syntax criteria. • Not all required information provided. • Staff is unable to authenticate information provided.	Not meeting the SLAs Inaccurate content information
Performance Measures	• Time to complete business process = within ___days • Accuracy with which edits are applied =___% • Consistency of decisions and disposition = % • Error rate = ___% or less	Providers and MCOs must notify us within 5 business days if any of their information changes (address, name, etc.) Providers and MCOs: Accuracy: For PES 100% accuracy 98% of the time. For MCOs not currently tracked.

BR Standards Management		
Manage Business Relationship Information		
Item	**Details**	**DMAS Differences/Comments**
		Compliance Officer recently hired so this may change. Consistency: for major changes only a record of the change is kept but not tracked as a metric. Error rate is not tracked. Budgets and Contracts: Time to complete: is driven by external factors that are unique to the contract, but no established standard for time to complete. Accuracy: 100% both parties review changes Consistency of decisions and disposition: NA Error rate: zero %

3.1.1.3.2 As-Is Assessment

The overall rating for the Manage Business Relationship Information business process is '2.' The process steps at DMAS are very similar to the MITA process steps with the addition of DMAS initiated information updates that take place on a recurring scheduled basis. The process is relevant to EDI trading partners, Managed Care Plans (MCO), state and federal agencies as well as vendors that we contract with. DMAS is compliant with HIPAA 5010 standards.

Other items noted in the As-Is assessment were:

- Providers and MCOs are expected to notify DMAS within 5 business days if any of their information changes.
- DMAS recently hired a Managed Care Compliance Officer to ensure that MCO plans are adhering to quality and timeliness requirements.

3.1.1.3.3 To-Be Assessment

DMAS intends to achieve Level 3 for the Manage Business Relationship Information business process.

Specific objectives include:

- Development of standardized metrics that are relevant to each business area to measure timeliness, accuracy, consistency, and error rates
- Use of a centralized repository for storage and retrieval of business relationship information
- Use of State and National information hubs when relevant to the business area

Meeting these objectives will result in greater consistency of process across business areas, improved quality of data and access to data available for decision making.

3.1.1.3.4 Scorecard

The following scorecard was compiled for the Manage Business Relationship Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
BR Standards Management ***Manage Business Relationship Information***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		

Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.1.1.4 Terminate Business Relationship

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Terminate Business Relationship business process.

3.1.1.4.1 Business Process Model

The Terminate Business Relationship business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

BR Standards Management		
Terminate Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Terminate Business Relationship*** business process cancels the agreement between the State Medicaid Agency (SMA) and the business partner such as the intrastate, interstate and federal agencies.	Relevant to Contracts, IAGs, Providers, Clearinghouses, MCO Plans.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive request for termination of agreement from internal or external sources. • Notification that the agreement has expired or a one-time information exchange process is complete. • External sources could be a receipt of a	Bankruptcy or near-bankruptcy For cause terminations, e.g. violation of terms of agreement, based on health, safety, and welfare of the members. Other examples include fraud or conviction of a felony. Internal Audit, fraud and abuse hotline.

BR Standards Management		
Terminate Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
	vendor purchased by another.	Newspaper articles. Bureau of Insurance (BOI) will notify us of solvency issues.
Result	• Business Relationship terminated. The SMA does not share additional information. • Alert to send notification to business partner of termination. • Tracking information as needed for measuring performance and business activity monitoring.	We don't measure performance or monitor business activity after the date of termination.
Business Process Steps	1. **START:** Receive request for business relationship termination. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information authentic. 4. Evaluate impact of termination of business relationship to business operations. 5. Terminate business relationship and related Service Level Agreement (SLA), Memoranda of Understanding (MOU), and such. 6. **END:** Send alert to notify business partner of termination.	Receive or Initiate request to terminate. MOU is same as Inter-Agency Agreement (IAG) in our agency. Also notify other business partners who will be impacted by the termination.
Shared Data	Business Partner data store including service agreements information Contractor data store including contract information	MCO and Provider data stores. Federal OIG database MCSIS database

BR Standards Management		
Terminate Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
		To Be: Notify Department of Health Professions
Predecessor	**Receive Inbound Transaction** ***Manage Business Relationship Information*** ***Close Out Contract***	***Establish Business Relationship*** (e.g. Nursing Home or MCO, need to place members with a new facility or plan)
Successor	**Send Outbound Transaction** ***Manage Business Relationship Communication***	
Constraints	The SMA and its business partners agree on the content of the termination message. Content depends on the business relationship. Content is standards-based.	Not applicable. Contractual lead time to terminate.
Failures	• Information does not comply with syntax criteria. • Not all required information provided. • Information provided not authenticated.	An appeal could cause a termination to fail. A **Corrective Action Plan** might be implemented
Performance Measures	• Time to complete business process = within ___days • Accuracy with which edits are applied = % • Consistency of decisions and disposition = % • Error rate = ____% or less	MCO Contracts requires a certain amount of time to terminate. Providers: We must notify them 30 days prior to the termination unless potential harm to members health, safety and welfare. Accuracy of terminations: 100% but we don't track it. For example in the case of a provider loses his license, we retroactively

BR Standards Management		
Terminate Business Relationship		
Item	**Details**	**DMAS Differences/Comments**
		terminate back to the day the provider's license was terminated. Accuracy not tracked for MCOs. Consistency is applied 100% of the time. Error rate: Less than 5 % of provider terminations are reversed on appeal. No standard for BCM contracts and IAGs. Need to address Providers and MCOs separately. Accuracy: 100% Consistency: NA Error Rate: zero %

3.1.1.4.2 As-Is Assessment

The overall rating for the Terminate Business Relationship business process is '2.' Quality and accuracy of this process is considered to be good overall with very few errors, for example, less than 5 % of provider terminations are reversed on appeal. Some level of collaboration with other agencies takes place, for example we make use of federal and State databases to automatically identify providers who should be terminated.

Other items noted in the As-Is assessment were:

- We must notify Providers 30 days prior to the termination unless potential harm to member's health, safety and welfare or provider license terminated.
- MCO contracts usually provide 6 months notice prior to termination unless other reasons for the termination, e.g. financial, or if both parties agree to terminate the contract sooner.

3.1.1.4.3 To-Be Assessment

The Terminate Business Relationship business process covers several types of business relationships. It is not always practical to standardize processes due to the different requirements for the business agreements in place for each type. The following are some areas that may be improved taking this

business process up to a capability rating of '3'.

- Notify Department of Health Professions that a trading partner has been terminated
- Begin tracking metrics for timeliness and accuracy of terminations
- Standardize termination procedures when appropriate for the different types of trading partners, i.e. Vendors, MCOs, Providers, Inter-agency Agreements
- Increase use of automated termination procedures when DMAS is notified by in-state and external entities that a trading partner meets the criteria to be terminated.

3.1.1.4.4 Scorecard

The following scorecard was compiled for the Terminate Business Relationship business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
BR Standards Management Terminate Business Relationship	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		

Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.2 CARE MANAGEMENT

OVERVIEW

The Care Management business area illustrates the increasing shift away from the fee-for-service model of care. Care Management collects information about the needs of the individual member, plan of treatment, targeted outcomes, and the individual's health status. It also contains business processes that have a common purpose (e.g., identify members with special needs, assess needs, develop treatment plan, monitor and manage the plan, and report outcomes). This business area includes processes that support individual care management and population management. Population management targets groups of individuals with similar characteristics to promote health education and awareness. The Electronic Health Record (EHR), Electronic Medical Record (EMR), and Personal Health Record (PHR) are typically primary sources of individual health information from the Health Information Exchange (HIE), however they are not currently utilized by DMAS for Virginia Medicaid.

Care Management includes Disease Management, Catastrophic Case Management, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Population Management, Patient Self-Directed Care Management, national health registries, and Waiver Program Case Management. The Care Management business area is responsible for the case management, authorizations, referrals, and treatment plans data stores. Care Management also contains business processes for authorization determination including authorizing referrals, service and treatment plans.

The Care Management BPM business area and its supporting business capabilities and business processes are depicted below in Figure 3.2-1.

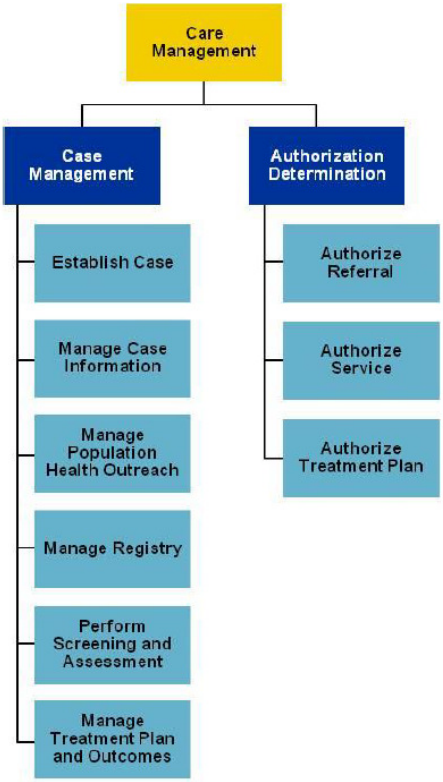

Care Management
Case Management
Authorization Determination
Establish Case
Manage Case Information
Manage Population Health Outreach
Manage Registry
Perform Screening and Assessment
Manage Treatment Plan and Outcomes
Authorize Referral
Authorize Service
Authorize Treatment Plan

Figure 3.2-1

BUSINESS ARCHITECTURE PROFILE

The Care Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Care Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Establish Case		As-Is	To-Be		
Manage Case Information		As-Is	To-Be		
Manage Population Health Outreach		As-Is	To-Be		
Manage Registry	As-Is NA		To-Be NA		
Perform Screening and Assessment		As-Is	To-Be		
Manage Treatment Plan and Outcomes		As-Is	To-Be		
Authorize Referral	As-Is NA		To-Be NA		
Authorize Service		As-Is	To-Be		
Authorize Treatment Plan		As-Is	To-Be		

3.2.1 Case Management

As shown in Figure 3.2-1, the Case Management business category is made up of six business processes:

- Establish Case
- Manage Case Information
- Manage Population Health Outreach
- Manage Registry
- Perform Screening and Assessment
- Manage Treatment Plan and Outcomes

Details regarding the assessment of each Case Management business process follow.

3.2.1.1 Establish Case

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Establish Case business process.

3.2.1.1.1 Business Process Model

The Establish Case business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CM Case Management		
Establish Case		
Item	**Details**	**DMAS Differences/Comments**

Description	The Care Management, ***Establish Case*** business process uses criteria and rules to:
	• Identify target members for specific programs.
	• Assign a care manager.
	• Assess the member's needs.
	• Select a program.
	• Establish a treatment plan.
	• Identify and confirm provider.
	• Prepare information for communication.
	
	This business process may establish a case for one individual, a family or a target population such as:
	• Medicaid Waiver program case management
	  o Home and Community-Based Services (HCBS)
	  o Other
	• Disease management
	• Catastrophic cases
	• Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
	• Vaccines for children and adults
	• Population management
	
	This business process may initiate a case from claim processing indicators such as:
	• Several claims for an individual member over a time interval.
		Member (or family care giver, doctor or DSS) self-refers to get these services initiated.
		
		DMAS provides Care coordination for Tech Waiver only.
		
		No case management for Nursing Facilities, EDCD, Alzheimer's, Home Health, Hospice, or DME.
		
		PACE case management is performed by the PACE team.
		
		Tech Waiver case management is performed by the agency in consultation with Tech Waiver staff at DMAS who serve in an advisory/review role only.
		
		EPSDT limited care coordination, linking folks to providers, referrals to services.
		
		For Tech Waiver the following are applicable:
		• Assess the member's needs.
		• Select a program.
		• Establish a treatment plan.
		• Identify and confirm provider.
		• Prepare information for communication.

	• New claims close to discharge date.
	• Claims containing one of the with the following:
	  ○ Place of Service – Certain Places of Service
	  ○ Discharge Date
	  ○ Admit Date
	  ○ PWK - Attachments containing lab results, treatment plans, etc.
	  ○ NTE - Notes containing discharge plans, goals, treatment plan
	  ○ EPSDT Referral Claim
	  ○ Claims containing certain types of the following information:
	  ✓ Principle Diagnosis
	  ✓ Admitting Diagnosis
	  ✓ Patient Reason for Visit
	  ✓ Other Diagnosis Information
	  ✓ Principle Procedure
	  ✓ Other Procedure
	  ✓ Condition Info
	  ✓ Treatment Code
	  ○ Prescription drug claim
	  ○ CLIA certification
	  ○ Home Health claim
	  ○ Test Result
	
	Different criteria and rules, relationships, and information define each type of health care case and require different types of external investigation.
	
	The Health Information Exchange (HIE) provides health information and clinical records for member and care coordination with provider and other agencies.
		DD and ID Waivers have a form of Case Management that is housed and handled by Virginia Department of Behavioral Health & Developmental Services (DBHDS).
		
		CCC is consistent, the MMPs handle care management.
		
		For Behavioral Health, care management takes place at Magellan.
		
		No HIE involvement for Long Term Care, PACE, Managed Care, or Magellan.
		
		• Vaccines for children up to age 20
		• Vaccines for adults include flu and pneumonia but only if at risk
		• Population management - Not applicable in VA

Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic review to scan for new cases is due. • Request to look into a specific case. Interaction-based Trigger Events to include but not limited to:	The following are not applicable in VA: • Periodic review to scan for new cases is due. • Receive information to establish a case (e.g., Electronic Data Interchange (EDI)).

	• An alert triggered by other events, such as a targeted diagnosis or referral generated from information submitted on a claim. • Receive enrollment of member from ***Enroll Member*** business process. • Receive information to establish a case (e.g., Electronic Data Interchange (EDI)).	The typical scenario is that DMAS receives a request to look into a specific case, to resolve an issue. It is not true case management, more like responding to a request. DMAS provides administrative oversight to some portions of the process. The screening teams do the initial assessments; the services are authorized through the service authorization contractor (KePRO) for waiver services. Magellan handles the Behavioral Health services. See the DMAS website for information about screenings, waivers, long term care processes: http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx
Result	• List of members associated with cases and programs. • Assessment of the needs of the member for care management. • Treatment Plan for member. • Associated Providers List. • Case file information. • Communications information for providers and members. • Alert to notify member of care management case. • Tracking information as needed for measuring performance and business activity monitoring.	DMAS provides oversight but our contractors actually perform the work, with the exception of the Tech Waiver. DMAS does the tracking on the Tech Waiver. ID and DD Waivers are handled by DBHDS.

Business Process Steps	1. **START**: Identify candidates for new cases with specific criteria (e.g., patient characteristics, medical conditions, location, or age). 2. Identify information requirements and parameters to include such items as periods of time, data elements, and data relationships. 3. Identify new case(s) for care management based on requirements and parameters. 4. Create case record for each new case. 5. Assign care manager. 6. Care manager reviews health and clinical information from Health Information Exchange (HIE). 7. Assess the needs of the member for care management. 8. Based on needs, determine which program(s) is appropriate for the member. 9. Based on needs, establish treatment (care) plan that identifies the services the member needs to receive, the types of providers, the care setting, frequency, and expected results. 10. Based on the treatment plan, select providers to deliver the services, contact and confirm availability, record decisions. 11. Record care management determination and related information. 12. **END:** Send alert to notify member of care management case.	Most of the process steps described in the MITA framework are handled by our contractors or by the providers. Step 1 is handled by our contractors or the providers based on self-referral by the members and their care givers. For Tech Waiver: We don't do steps 1, 2, 3, and 6, and step 8 has already been done. Step 9 we review the treatment plans. Step 10 is already done by the time we receive the treatment plan. Step 11 We have an Oracle Tech Waiver database on the cases.
Shared Data	Member data store including demographics Health Information Exchange (HIE) data store including health information, clinical record and clinical information	KEPRO, Magellan, PPL, VAMMIS, pre-admission screening data. Tech Waiver DB, LOCERI DB (level of care), PACE DB

	Enterprise Master Patient Index (EMPI) for single and complete view of patient information Provider data store including provider network information Health Benefits data store including programs and services Information	We do not share data with HIE or EMPI.
Predecessor	**Receive Inbound Transaction** ***Enroll Member*** ***Manage Applicant and Member Communication*** ***Manage Member Grievance and Appeal*** ***Identify Utilization Anomalies***	Most of this is all decided by the providers. For tech waivers, these are partially applicable. Tech Waiver staff oversee the member's health, safety, and welfare as it relates to the provision of tech waiver services. Typically, tech waiver staff are not involved in the grievance and appeals process as it is the provider who would actually perform these functions is a denial of services is made through the service authorization process. LTC staff to assist with complaints related to all services handled in LTC and assist members with the disposition of the complaints by either resolving the complaint to their satisfaction or ensuring they understand the regulations regarding the service denial. LTC staff do not participate in appeals. LTC staff may identify anomalies through the quality management review process.
Successor	**Send Outbound Transaction** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Authorize Treatment Plan*** ***Manage Treatment Plan and Outcomes***	Most of these successor tasks are handled by the providers.

Constraints	States and programs within States use different criteria to establish cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. States will conform to required Affordable Care Act requirements for EPSDT and immunizations case management.	
Failures	• Details of the case are inconsistent with criteria; discontinued case.	Lack of adequate provider network. Change in financial status, loss of Medicaid eligibility.
Performance Measures	• Time required to establish a case. • Effectiveness of selection criteria in determining real cases.	The time required to establish a case varies, based on how long it takes to establish provider, eligibility, outside agencies. No metrics kept. For Behavioral Health and CCC, MMPs have contracted time requirements. Effectiveness: LOCERI annual review process document and Medicaid Memo that went out in March to providers defining the LOCERI process.

3.2.1.1.2 As-Is Assessment

The overall rating for the Establish Case business process is '2.' Most of the process steps described in the MITA framework are handled by our contractors, managed care plans or by the providers.

Other items noted in the As-Is assessment were:

- DMAS provides care coordination for Tech Waiver only.
- EPSDT limited care coordination, linking folks to providers, referrals to services.
- PACE case management is performed by the PACE team.
- Tech Waiver case management is performed by the agency in consultation with Tech Waiver staff at DMAS who serve in an advisory/review role only.
- No case management is performed for Nursing Facilities, EDCD, Alzheimer's, Home Health, Hospice, or DME.
- DD and ID Waivers have a form of case management that is owned and handled by

Virginia Department of Behavioral Health & Developmental Services (DBHDS).
- The Health Information Exchange (HIE) health information and clinical records are not used for member and care coordination with provider and other agencies.

3.2.1.1.3 To-Be Assessment

In Virginia, most of the Establish Case business process is handled by our contractors, managed care plans or by the providers. As Virginia continues to expand its use of Managed Care Plans and vendors such as Magellan for Behavioral Health services, this trend is not expected to change.

The following areas of possible improvement noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Establish Case business process:

- Establish meaningful metrics to track the accuracy and timeliness in which the cases are handled.
- DBHDS plans to create a web-enabled waiver management system to make process more efficient.
- Utilize the Health Information Exchange (HIE) data store including health information, clinical record and clinical information to improve effectiveness of member care coordination.
- Move toward the creation of an Enterprise Master Patient Index (EMPI) for single and complete view of patient information used by all business areas involved in Case Management at the agency.
- The goal of these changes is to reduce the amount of time needed to perform required assessments and establish a case.
-

3.2.1.1.4 Scorecard

The following scorecard was compiled for the Establish Case business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CM – Case Management Establish Case	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	1	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		

Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.2.1.2 Manage Case Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Case Information business process.

3.2.1.2.1 Business Process Model

The Manage Case Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CM Case Management		
Manage Case Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Case Information*** business process uses state-specific criteria and rules to ensure	

CM Case Management		
Manage Case Information		
Item	**Details**	**DMAS Differences/Comments**
	appropriate and cost-effective medical, medically-related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as: • Medicaid Waiver program case management • Home and Community-Based Services (HCBS) • Other agency programs • Disease management • Catastrophic cases • Early Periodic Screening, Diagnosis, and Treatment (EPSDT) • Immunizations for children and adults The ***Establish Case*** business process creates each individual case and treatment plan. The ***Manage Case Information*** business process includes activities to confirm delivery of services and compliance with the plan. It also includes activities such as: • Service planning and coordination. • Facilitation of services (e.g., finding providers, or establishing limits or maximums). • Advocating for the member. • Monitoring and reassessment of services	

CM Case Management		
Manage Case Information		
Item	**Details**	**DMAS Differences/Comments**
	for need and cost effectiveness. o This includes assessing the member's placement and the services received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs. The Health Information Exchange (HIE) provides health information and clinical records for member and care coordination with provider, pharmacist, and other agencies records for member and care coordination with provider, pharmacist, and other agencies.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g. monthly, quarterly) review of a case is due. • Monitor member's case activity. • Receive case modifications (e.g., create, update, or delete). Interaction-based Trigger Events to include but not limited to: • Receive information regarding services delivered/not delivered (including claims information). • Receive health plan or health	Annual LOCERI review, EDCD, AAL, Tech Waiver, PACE reviews every 6 months, etc. as documented in the VA Administrative Code. Bi-Annual visits are conducted for Tech Waivers. For CCC reference notes see: http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx For Behavioral Health reference notes see: http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx For EPSDT regulation citations see: http://www.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_fs.pdf DBHDS for ID/DD waivers.

CM Case Management		
Manage Case Information		
Item	**Details**	**DMAS Differences/Comments**
	benefit modification that may affect a treatment plan. • Receive information regarding an enrollment modification, including disenrollment. • Receive information regarding modification in member's conditions or situation	

Result	• Updated case history with possible revision to the following:
	  o Case history
	  o Needs assessment
	  o Treatment Plan
	  o Associated Providers List
	  o Case file information (e.g., contact dates and times)
	• Content of communications sent to providers and members.
	• Tracking information as needed for measuring performance and business activity monitoring.
	
	  o QIT data indicators… quarterly, QRT..quality review tracking
	
	CCC has monthly measure, quarterly indicators.
	Emily will send out docs, Jill will research the process
		All of these results would be the responsibility of the Providers with the exception of Tech which does all of these results.
		
		• Tracking information as needed for measuring performance and business activity monitoring.
		
		QIT Quality Indicators, Quarterly
		QRT Quality Review Tracking (get from DBHDS), Quarterly
		CCC has quarterly quality indicators, see CCC documents
		Magellan has annual quality indicators, see Magellan documents

Business Process	1. **START:** Receive request to review	ID/DD Waivers follow the MITA process steps .

CM Case Management		
Manage Case Information		
Item	**Details**	**DMAS Differences/Comments**
Steps	case (review of the member's status and needs). 2. Based on review, take follow-up action, as needed, to: o Identify services delivered, issues impeding delivery of service and/or member's progress. o Establish appointment with member to review case status. o Contact provider(s) to review member's progress. o Review services provided (claims payment information). o Close case for non-chronic conditions or change in member's status. 3. Revise treatment plan to: o Add or remove services. o Change nature of plan (e.g. shifting drug regimen, shifting from drug to behavioral). o Reassess needs. o Revise expected results.	Tech Waiver, reviews services provided, not necessarily from the claims side. For EDCD, AAL and PACE this is done at the provider level. For CCC the plans are doing the MITA process steps. For Magellan, they are doing similar process steps.

CM Case Management		
Manage Case Information		
Item	**Details**	**DMAS Differences/Comments**
	4. **END:** Send alert to notify of care management modifications or care coordination updates.	
Shared Data	Member data store including demographics NA- Health Information Exchange (HIE) data store including health information, clinical record and clinical data NA-Enterprise Master Patient Index (EMPI) for single and complete view of patient information Provider data store including provider network information Health Benefits data store including programs and services Information Case History data store including action lists, journal notes, reviews and approvals	The following shared data are not applicable in VA: NA- Health Information Exchange (HIE) data store including health information, clinical record and clinical data NA-Enterprise Master Patient Index (EMPI) for single and complete view of patient information See notes from Establish Case. Case History would include: KEPRO, VAMMIS, Oracle DBs, paper documentation., PPL (aka Fiscal Employer Agent).
Predecessor	**Receive Inbound Transaction** ***Perform Screening and Assessment*** ***Establish Case*** ***Authorize Referral*** ***Authorize Service*** ***Authorize Treatment Plan*** ***Manage Treatment Plan and Outcomes***	We agree that all of these would be predecessor processes. Most of these processes are done outside of DMAS with the exception of the Tech Waiver where some of these processes are done here at DMAS.
	Send Outbound Transaction	Applicable to TECH Waiver:

CM Case Management		
Manage Case Information		
Item	**Details**	**DMAS Differences/Comments**
Successor	***Authorize Treatment Plan*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Population Health Outreach*** ***Manage Registry – PACE, Immunization registry, HCS, MCH.*** ***Submit Electronic Attachment*** ***Manage Data***	1. ***Manage Applicant and Member Communication*** 2. ***Manage Provider Communication*** We agree that these are appropriate successor processes. Most of these are done by our contractors or the providers. We don't think that the Manage Registry process occurs. Immunization registry might be an example of one that might be taking place.
Constraints	States and programs within States use different criteria to manage cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. States will conform to required Affordable Care Act requirements for EPSDT and immunizations case management.	Agree that these are appropriate constraints.
Failures	• Information required to manage case is not available or is inaccurate.	Lack of adequate provider network. Change in financial status, loss of Medicaid eligibility.
Performance Measures	• The State Medicaid Agency (SMA) updates cases within the timeframe specified by state policy. • Movements towards desired health care outcomes because of improvements in case management practices.	First bullet is not applicable Second bullet may be applicable to BHSA and CCC.

3.2.1.2.2 As-Is Assessment

The overall rating for the Manage Case Information business process is '2.' Most of the process steps described in the MITA framework are handled by our contractors, managed care plans or by the providers.

Other items noted in the As-Is assessment were:

- For Elderly or Disabled with Consumer Direction Waivers (EDCD), Alzheimer's Assisted Living Waiver (AAL) and Program of All-Inclusive Care for the Elderly (PACE), the MITA process steps are done at the provider level.
- The Intellectual Disability (ID) and Developmental Disability (DD) Waivers follow the MITA process steps.
- For the Technology Assisted Waiver (Tech), services provided are reviewed but not necessarily from the claims side.
- For Commonwealth Coordinated Care (CCC) and Medallion 3.0, the plans are following the MITA process steps.

3.2.1.2.3 To-Be Assessment

Completion of the following areas of possible improvement that were noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Manage Case Information business process:

- DBHDS plans to create a web-enabled waiver management system to make process more efficient.
- Utilize the Health Information Exchange (HIE) data store including health information, clinical record and clinical information to improve member health outcomes.
- Move toward the use of an Enterprise Master Patient Index (EMPI) for single and complete view of patient information used by all business areas involved in Case Management internal and external to DMAS.
- Improve the consistency of member case data that is used to analyze health outcomes and make program improvements.
- Establish meaningful metrics to track member health outcomes.

3.2.1.2.4 Scorecard

The following scorecard was compiled for the Manage Case Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CM – Case Management Manage Case Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***

Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.2.1.3 Manage Population Health Outreach

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Population Health Outreach business process.

3.2.1.3.1 Business Process Model

The Manage Population Health Outreach business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CM Case Management		
Manage Population Health Outreach		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Population Health Outreach*** business process is responsible for the implementation of strategy to improve general population health. The State Medicaid Agency (SMA) identifies target populations or individuals for selection by cultural, diagnostic, or other demographic indicators. The inputs to this business process are census, vital statistics, immigration, and other information sources. This business process outputs materials for: • Campaigns to enroll new members in existing health plan or health benefit. • New health plan or health benefit offering. • Modification to existing health plan or health benefit offering. It includes production of information materials and communications to impacted members, providers, and contractors (e.g., program strategies and materials, etc.). The communication of information includes a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI).	Enrollment is not applicable to Long Term Care, at least not handled by DMAS. For Long term care and PACE we don't do these activities at DMAS however the participating providers do this. Magellan identifies members based on use of services, educational outreach to help improve health outcomes and use of medications. Communication goes out to providers and members. CCC program, outreach is focused on education about what the program offers. Town halls done by DMAS staff and MCO staff to educate both members and providers. Modifications to existing health plan, we send Medicaid Memos to providers. Need to follow-up with HCS for more info about what the MCOs do. Maternal and Child Health has

CM Case Management		
Manage Population Health Outreach		
Item	**Details**	**DMAS Differences/Comments**
		a marketing person who coordinates outreach, marketing materials to members and to a lesser extent to providers.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive information from census, vital statistics, public health departments, immigration, and other information sources. • Periodic timetable (e.g., monthly, quarterly) to distribute information is due. • Receive new population or problem-specific legislated health improvement initiatives. • Receive request for information from other originators (e.g., federal actions or constituency interests). Interaction-based Trigger Events to include but not limited to: • Receive alert from Establish Case to place member into care management monitoring.	Regulatory Changes for on-going programs. Events such as school shootings or other tragedies that might generate requests for additional education outreach. Last bullet may be applicable to CMM, Linda Haywood is SME.
Result	• The SMA produces outreach communications (e.g., mailing brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements) and distributes to targeted populations or individuals. The SMA may also conduct face-to-face meetings.	Magellan tracks reasons for calls. The Provider Help Line tracks calls in and responses. Omnitrack is used by Xerox for

CM Case Management		
Manage Population Health Outreach		
Item	**Details**	**DMAS Differences/Comments**
	• Tracking information as needed for measuring performance and business activity monitoring.	provider help line. DMAS tracks returned mail. DMAS track PINKS and responses. DMAS has a RECIPIENT help line in the CMM unit. Linda Haywood is DMAS SME. They track calls and responses.
Business Process Steps	1. **START:** Receive request for outreach materials or communication. 2. Target population identified and defined by analyzing information, performance measures, feedback from community, and policy directives. 3. Approve, deny, or modify decisions to develop outreach communications. 4. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web or EDI). 5. Determine performance measures. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message sent to target population. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).	#4. We don't send to mobile devices #5. Performance measures are not a part of our process other than the exceptions noted above 6. We typically send materials in English and Spanish and at a 4th grade reading level, cultural not applicable. 10. is not applicable for the most part other than with Magellan, CCC and PACE providers do a customer satisfaction questions and CCC does focus groups.
Shared Data	Member data store including demographic information Provider data store including provider network Information	VDH and DSS are the only ones relevant to the last bullet.

CM Case Management		
Manage Population Health Outreach		
Item	**Details**	**DMAS Differences/Comments**
	Contractor data store including provider network Information Plan data store including policy information Health Benefit data store including program and service information Data from external agencies including: census, vital statistics, immigration, and various health registries	
Predecessor	There are several business processes that can result in the interest or need to reach out to the Medicaid population in an attempt to improve behavior or promote prevention: ***Identify Utilization Anomalies*** ***Manage Performance Measures*** ***Manage Member Grievance and Appeal*** ***Manage Provider Grievance and Appeal*** ***Manage Health Plan Information***	
Successor	***Manage Applicant and Member Communication*** ***Perform Population and Member Outreach*** ***Manage Provider Communication*** ***Perform Provider Outreach*** ***Manage Contractor Communication*** ***Manage Performance Measures***	
Constraints	Agencies do not coordinate amongst each other in order to share information. Potential political and inter-agency conflicts over appropriate use of health care information.	We don't always have accurate/current address information for members.
Failures	• Inter-agency agency communication or lack of access to information impairs ability to gather information to support strategies.	Retro-Eligibility, eligibility status is not always current in our system, may cause members to miss outreach attempts.
Performance Measures	• Time to complete communication: By phone__ minutes; by email ____ hours; by mail __ days	Provider Medicaid Memos, no later than 30 days prior to the

CM Case Management		
Manage Population Health Outreach		
Item	**Details**	**DMAS Differences/Comments**
	• Accuracy of communications = __% • Communications successfully delivered =__ %	change. 100% Accuracy Issues with email, not required field, snail mail, frequent changes, we estimate between 8 % and 15 % mail is returned, however this is not tracked.

3.2.1.3.2 As-Is Assessment

The overall rating for the Manage Population Health Outreach business process is '2.' The MITA model is consistent with the process steps performed by the DMAS business areas with the exception of Long Term Care and PACE. For those business areas, the participating providers perform the steps similar to the MITA model.

Other items noted in the As-Is assessment were:

- Medallion 3.0 identifies members based on use of services
- Educational outreach to providers and members is used to help improve health outcomes and use of medications.
- Town halls are offered by DMAS and MCO staff to educate both members and providers about what the CCC program offers.
- Medicaid Memos are sent to Fee for Service providers when modifications to the existing health plans occur.
- The Maternal and Child Health division at DMAS sends marketing materials to members and providers.

3.2.1.3.3 To-Be Assessment

Completion of the following areas of possible improvement that were noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Manage Population Health Outreach business process:

- Automate the outreach process where appropriate based on member demographics and utilization of services.

- Establish Population Health Outreach business process performance measures.
- Periodically review the need to prepare content that is linguistically and culturally appropriate for the populations being served. Currently materials are sent out in Spanish and English and are written at a 4th grade reading level, however special linguistic or cultural adaptations are not needed at the present time.
- Establish consistent metrics and processes to evaluate the efficacy of the communication such as customer satisfaction, first time resolution rate, successful delivery, etc.

3.2.1.3.4 Scorecard

The following scorecard was compiled for the Manage Population Health Outreach business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CM – Case Management Manage Population Health Outreach	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		

Supporting Evidence Reference	
Utility or Value to Stakeholder	2 3
Performance Measure	
Supporting Evidence Reference	

3.2.1.4 Manage Registry

The Manage Registry business process is not applicable to the Virginia Medicaid program.

3.2.1.5 Perform Screening and Assessment

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Perform Screening and Assessment business process.

3.2.1.5.1 Business Process Model

The Perform Screening and Assessment business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CM Case Management		
Perform Screening and Assessment		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Perform Screening and Assessment*** business process is responsible for the evaluation of member's health information, facilitating evaluations and recording results. This business process assesses for certain health and behavioral health conditions (e.g., chronic illness, mental health, substance abuse), lifestyle and living conditions (e.g., employment, religious affiliation, living situation) to determine risk factors. This business process: • Establishes risk categories and hierarchy, severity, and level of need. • Screens for required fields. • Edits required fields.	GAP Screenings will be handled by Magellan. Long Term Care pre-admission screening is contracted out. The local health departments and local departments of social services or the acute care hospitals. Tech Waiver: Screening is done by the same screening teams. DMAS reviews and gives final approval for the Tech Waiver. Once the screening has been completed, the Assessments are sent to Xerox for processing where the system creates a claim (CT 96) and are processed for payment in VAMMIS.

CM Case Management		
Perform Screening and Assessment		
Item	**Details**	**DMAS Differences/Comments**
	• Verifies information from external sources if available. • Establishes severity scores and diagnoses. • Associates with applicable service needs. Health Information Exchange (HIE) verifies a member's health information.	DBHDS: for DD Waiver, screenings are done by the Child Development Clinics, for ID and Day Support Waiver; screenings are done by the CSBs. House Bill 702 may change some of these screenings. Possibly different players for some of these waiver screenings. Need to review in Dec 2015. The HIE verification step is not applicable to Virginia Medicaid. We consider the screening to be the determination of eligibility for admission to a program. EPSDT screenings are not included in this Screening and Assessment process. EPSDT screenings are more like an evaluation for services.
Trigger Event	Interaction based Trigger Events: • Receive new member enrollment alert from ***Enroll Member*** business process. • Receive redetermination of member enrollment alert from ***Enroll Member*** business process.	These are not our trigger events in Virginia. This assessment process is triggered by the member/applicant's, family, doctor, hospital discharge planner, etc.
Result	• Member notified of applicable services as needed. • Tracking information as needed for measuring performance and business activity monitoring.	We do not currently do the second bullet, (tracking information). The new provider screening portal will track information about requests for screening and dates screening completed. This functionality is scheduled to start in January 2015. The screening information will ultimately be stored in VAMMIS. This only applies to AAL, Tech, EDCD, Nursing Facility, PACE and Assisted Living. It doesn't apply to services to ID, DD, and Day Support

CM Case Management		
Perform Screening and Assessment		
Item	**Details**	**DMAS Differences/Comments**
		waivers which are administered by DBHDS. For GAP: Magellan will be doing the second bullet. Magellan will be tracking and reporting it to DMAS.
Business Process Steps	1. **START:** Receive new member or redetermination of member enrollment from ***Enroll Member*** business process. 2. Assign Care Manager. 3. Gather information for history and/or examinations. 4. Determine risk factors and establish risk categories. 5. Conduct needs assessment and determines level of need. 6. Determine health benefits that are appropriate for the member. 7. Staff records screening and assessment results. 8. Associate member to applicable services based on results. 9. **END:** Send alert to notify member of applicable services based on screening and assessment.	Step 1 is not applicable. Step 2 only occurs for Tech and Disability Waivers (ID, DD, and DS). Step 3 is done by the screening contractors for the most part. We sometimes receive history and examination information as part of the screening packet. Step 4: is not applicable. Step 5: For Tech Waiver the contractor sends in the screening, DMAS reviews it, validates the level of need and in some cases revises it. For the other waivers, Nursing Facility and PACE, step 5 is done by the screening contractors. Step 6: For Tech Waiver this step is done by DMAS. For the other waivers, Nursing Facilities, and PACE step 6 is done by the screening contractors. Step 7: For Tech Waiver this step is done by DMAS. For the other waivers, Nursing Facilities, and PACE step 7 is done by the screening contractors. Step 8: is done once the member chooses the provider. Step 9: For Tech Waiver this step is done by DMAS. For the other waivers, Nursing Facilities, and PACE step 9 is done by the screening contractors.

CM Case Management		
Perform Screening and Assessment		
Item	**Details**	**DMAS Differences/Comments**
		For GAP: Magellan does all 9 steps.
Shared Data	Member data store including demographic information Health Information Exchange (HIE) data store including health information, clinical record and clinical data Plan data store including policy information Health Benefit data store including program and service information Case History data store including action lists, journal notes, reviews and approvals	Health Information Exchange is not applicable in VA. For Tech and DD waivers, there is a case history data store, but not for the other waivers, Nursing Facilities and PACE. The Tech Waiver data store is at DMAS in an Oracle database. The DD Waiver data store is at DBHDS. For Tech Waiver, there are also paper files, scanned documents on the J drive. DBHDS is currently creating a new database that will include case history for DD, ID and Day Support. For GAP, the behavioral case history will be at Magellan, shared with DMAS. The medical case history will be at DMAS and shared with Magellan via access to VAMMIS.
Predecessor	***Enroll Member***	Enroll Member is not an applicable predecessor for Long Term Care and GAP. The member/member applicant, doctor, family member requests for the member/member applicant to be screened.
Successor	***Manage Case Information*** ***Manage Applicant and Member Communication***	Determine Member Eligibility is another successor process.
Constraints	States may have different screening requirements and health benefits. Agencies do not coordinate between each other in order to share information.	

CM Case Management		
Perform Screening and Assessment		
Item	**Details**	**DMAS Differences/Comments**
	Potential political and inter-agency conflicts over appropriate use of health care information.	
Failures	• Care Manager is unable to acquire history and/or examination information.	The contractor is unable to acquire the necessary documentation to support the service.
Performance Measures	• Timeliness to complete process = within days • Accuracy with which changes are applied = _____% • Consistency of decisions and disposition =___ • Error rate = __% or less	Timeliness: For GAP the start to finish time to process is within 30 days. For the others, there is no specified time for the contractors to complete the screening and assessment process. Accuracy: We expect 100% accuracy but this is not measured due to the subjective nature of the process. Consistency and Disposition: We expect 100% consistency and disposition but this is not measured due to the subjective nature of the process. Error rate: should be 5% or less but this is not tracked.

3.2.1.5.2 As-Is Assessment

The overall rating for the Perform Screening and Assessment business process is '2.' The screening and assessment process is triggered by the member or applicant, his or her family, a doctor, a hospital discharge planner, etc. The process is considered to be accurate and efficient due to automation and state standards. In most cases, the screening is handled by entities outside of DMAS as a prerequisite to the assessment.

Other items noted in the As-Is assessment were:

- Several of the steps in this MITA business process are not applicable in Virginia.
- The HIE verification step is not applicable to Virginia Medicaid.
- We consider the screening to be the determination of eligibility for admission to a program.
- EPSDT screenings are not included in this Screening and Assessment process.

3.2.1.5.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Perform Screening and Assessment business process:

- Work with DMAS stakeholders and external stakeholders to establish appropriate time frames in which the Perform Screening and Assessment process must be completed, start to finish.
- Establish meaningful metrics to track the accuracy and timeliness in which the assessments are handled.
- Utilize the Health Information Exchange (HIE) data store including health information, clinical record and clinical information to improve effectiveness of member care coordination.
- Move toward the creation of an Enterprise Master Patient Index (EMPI) for single and complete view of patient information used by all business areas involved in Case Management at the agency.
- A new application on the DMAS provider web portal will track information about requests for screening and dates screening completed improving access to information and consistency of data.
- The goal of these changes is to reduce the amount of time needed to perform required assessments and establish a case.

3.2.1.5.4 Scorecard

The following scorecard was compiled for the Perform Screening and Assessment business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CM – Case Management Perform Screening and Assessment	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3

Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.2.1.6 Manage Treatment Plan and Outcomes

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Treatment Plan and Outcomes business process.

3.2.1.6.1 Business Process Model

The Manage Treatment Plan and Outcomes business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CM Case Management		
Manage Treatment Plan and Outcomes		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Treatment Plan and Outcomes*** business process uses federal and state specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes member and member population outcomes. It includes activities to track and assess effectiveness of the services,	This business process is applicable for GAP, CCC, and Tech Waivers. Health Information Exchange (HIE) is not applicable at DMAS. Budget does tracking for the

CM Case Management		
Manage Treatment Plan and Outcomes		
Item	**Details**	**DMAS Differences/Comments**
	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 member populations (e.g., pregnant women and children, and HIV/intravenous drug users). Health Information Exchange (HIE) monitors a member's health information.	Cost Effectiveness of the Waivers. For GAP CMS requires that we track budget neutrality. The providers perform this business process for the other waivers, Nursing Facilities, PACE and EPSDT.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receipt from Health Information Exchange (HIE) of a modification in member's health outcome. • Receive treatment plan from ***Establish Case*** business process. Environment-based Trigger Events to include but not limited to: • Periodic review of member's treatment plan is due. • Receive request to review member's treatment plan.	HIE is not applicable. For CCC the other trigger events are applicable. For the other waivers, PACE, Nursing Facilities, the provider performs bullets 2, 3, 4. For Tech Waiver, the provider is the one that completes the treatment care plan.
Result	Member's treatment plan and outcomes are appropriate for their needs. Send modification (e.g., creates, update, delete) to member's treatment plan sent to Health Information Exchange (HIE). • Member, provider and care coordinators notified of modifications in treatment plan or benefits. • Tracking information as needed for measuring performance and business	HIE not applicable. Bullet #1: correct Bullet #3: Depends on the program as to who receives the notifications. Always notify the Member and potentially the provider and care coordinator. Bullet #4: Only applicable to GAP and CCC.

CM Case Management		
Manage Treatment Plan and Outcomes		
Item	**Details**	**DMAS Differences/Comments**
	activity monitoring.	For LTC waiver services aggregate performance measures are captured for CMS.
Business Process Steps	1. **START:** Receive member's treatment plan from ***Establish Case*** business process. 2. Review of effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. 3. Determine if modifications are necessary for effective treatment outcome. 4. Record required modifications to member's treatment plan. 5. **END:** Send notification to member, provider and other care coordinators of modification in treatment or benefits. <u>Alternate Path:</u> 1. **START:** Receive treatment plan from Health Information Exchange (HIE). 2. Review of effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. 3. Determine if modifications are necessary for effective treatment outcome. 4. Record required modifications to member's	Step 1: The provider, the MMP, or the Contractor (Magellan) starts the process and develops the treatment plan/plan of care. Step2: The provider, the MMP, or the Contractor (Magellan) handles this step Tech Waiver also performs a 6 month review. Step 3: All treatment plans/plan of care are reviewed by DMAS or Service Authorization contractors (e.g. KePRO). No changes to steps 4 and 5 and Alternate Path does not apply.

CM Case Management		
Manage Treatment Plan and Outcomes		
Item	**Details**	**DMAS Differences/Comments**
	treatment plan. 5. Send notification to member, provider, and other care coordinators of modification in treatment or benefits. 6. **END:** Send modification to member's treatment plan or benefits to Health Information Exchange (HIE).	
Shared Data	Member data store including demographic and social information Health Information Exchange (HIE) data store including health information, medically-related social and support services, clinical record, and clinical data Case History data store including action lists, journal notes, reviews, and approvals	Health Information Exchange is not applicable at DMAS. Any contractor data bases related to Service Auth. For Tech and DD waivers, there is a case history data store, but not for the other waivers, Nursing Facilities and PACE. The Tech Waiver data store is at DMAS in an Oracle database. The DD Waiver data store is at DBHDS. For Tech Waiver, there are also paper files, scanned documents on the J drive. DBHDS is currently creating a new database that will include case history for DD, ID and Day Support. For GAP, the behavioral case history will be at Magellan, shared with DMAS. The medical case history will be at DMAS and shared with Magellan via access to VAMMIS.
Predecessor	**Receive Inbound Transaction**	

CM Case Management		
Manage Treatment Plan and Outcomes		
Item	**Details**	**DMAS Differences/Comments**
	Establish Case ***Authorize Treatment Plan***	
Successor	**Send Outbound Transaction** ***Authorize Treatment Plan*** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication***	
Constraints	Agencies do not coordinate amongst each other in order to share information. Potential political and inter-agency conflicts over appropriate use of health care information.	
Failures	• Care Manager is unable to acquire treatment plan information.	The contractor or provider is unable to acquire the necessary documentation to support the treatment plan/plan of care.
Performance Measures	• Timeliness to complete process = within days • Accuracy with which changes are applied = _% • Consistency of decisions and disposition = ____% • Error rate = __% or less	Timeliness: This process is an ongoing process as defined by regulatory authority associated with the service. Accuracy: We expect 100% accuracy but this is not measured due to the subjective nature of the process. Consistency and Disposition: We expect 100% consistency and disposition but this is not measured due to the subjective nature of the process. Error rate: should be 5% or

CM Case Management		
Manage Treatment Plan and Outcomes		
Item	**Details**	**DMAS Differences/Comments**
		less but this is not tracked.

3.2.1.6.2 As-Is Assessment

The overall rating for the Manage Treatment Plan and Outcomes business process is '2.' This business process is applicable for GAP, CCC, and Tech Waivers. The provider, the managed care plan, or the Contractor (Magellan) starts the process and develops the treatment plan/plan of care.

Other items noted in the As-Is assessment were:

- The Budget and Contract Management Division performs tracking for the Cost Effectiveness of the Waivers.
- The Health Information Exchange (HIE) is not yet used to monitor a member's health information in Virginia.
- All treatment plans/plan of care are reviewed by DMAS or Service Authorization contractors (e.g. KePRO).

3.2.1.6.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Manage Treatment Plan and Outcomes business process:

- Implement a central repository of member data including demographic, social information, and case history including action lists, journal notes, reviews, and approvals to provide all stakeholders with access to consistent and complete case information.
- DBHDS plans to create a web-enabled waiver management system to make process more efficient.
- Incorporate use of the Health Information Exchange (HIE) data store in the business process where appropriate to gain access to member's health information, medically-related social and support services, clinical record, and clinical data.
- Establish standardized and where possible automated processes to trigger reviews of treatment plans.
- Establish meaningful metrics to track the accuracy and timeliness in which the Manage Treatment Plan and Outcomes process is carried out as well as track member treatment outcomes.

3.2.1.6.4 Scorecard

The following scorecard was compiled for the Manage Treatment Plan and Outcomes business process

as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CM – Case Management Manage Treatment Plans and Outcomes	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.2.2 Authorization Determination

As shown in Figure 3.2-1, the Authorization Determination business category is made up of three business processes:

- Authorize Referral
- Authorize Service
- Authorize Treatment Plan

Details regarding the assessment of each Authorization Determination business process follow.

3.2.2.1 Authorize Referral

The Authorize Referral business process is not applicable to the Virginia Medicaid program.

3.2.2.2 Authorize Service

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Authorize Service business process.

3.2.2.2.1 Business Process Model

The Authorize Service business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CM Authorization Determination		
Authorize Service		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Authorize Service*** business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. Its primary use is in a fee-for-services setting. Prior authorization of a service request is a care management function and begins when a care manager requests a service request by mail, facsimile, telephone, or Accredited Standards Committee (ASC) X12 278 Health Care Services Review Information request transaction. The care manager evaluates requests based on state rules for prioritization such as urgency and type of service/taxonomy (e.g., durable medical equipment, speech, physical therapy, dental, and out-of-state), validates key information, and ensures that requested service is appropriate and medically necessary. After review, staff approves, modifies, denies or suspends for additional	VA does not use the X12 278 transaction for this business process. Service authorizations for VA are done by KePRO (SA Contractor), DBHDS, and internal DMAS staff. Drug authorizations are done by Provider Synergies (division of Magellan) as part of Pharmacy processing contract. Here is a list of who handles Service Auths and the associated services: DBHDS: ID and DD Waivers DMAS: Tech Waivers, EPSDT, SNF, Hospice Provider Synergies: Drug Logisticare: Transportation

CM Authorization Determination		
Authorize Service		
Item	**Details**	**DMAS Differences/Comments**
	information the service requests. The State Medicaid Agency (SMA) sends the appropriate response information for the outbound ASC X12 278 Health Care Services Review Response transaction to the provider using the **Send Outbound Transaction.** **NOTE:** MITA contains three (3) different authorization business processes: 1. ***Authorize Service*** – the standard process of prior authorization of services. 2. ***Authorize Treatment Plan*** – the approval of a treatment plan prepared by a care management team in a care management setting. 3. ***Authorize Referral*** – specifically the approval of a referral to another provider, requested by a primary care physician. A post-approved service request is an editing/auditing function that requires review of information after the service is complete. A review may consist of verifying documentation to ensure that the services were appropriate and medically necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the ***Process Claim*** **or** ***Process Encounter*** business processes. **NOTE:** This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, and Off- label use of drugs, Social Service, Experimental Treatments, Out-of-State Services, and Emergencies.	Magellan: BHSA Smiles for Children: Dental Post-approval review process is done as part of an audit function and not a normal standard business process incorporated into MMIS
Trigger Event	Interaction-based Trigger Events to include but not limited to: Receive service request from Health Information Exchange (HIE) via ASC X12 278 Health Care Services Review Request and Response transaction. Receive service request from requestor via ASC X12 278 Health Care Services Review Request and Response transaction. Environment-based Trigger Events to include but	No data received from HIE for VA business process. X12 278 transactions are not done for VA

CM Authorization Determination		
Authorize Service		
Item	**Details**	**DMAS Differences/Comments**
	not limited to: Provider submits a request for service in accordance with state policy. • Provider submits additional information for existing service authorization request.	
Result	• Service authorization response sent to requestor. • Alert to send service information to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Manage Applicant and Member Communication*** to send notification of authorized service response. • Alert sent to ***Manage Case Information*** business process for purposes of responding to provider or member inquiries about the status of service request or a provider or member filing of a grievance or an appeal about the service authorization response. • Tracking information as needed for measuring performance and business activity monitoring.	KePRO does not use a 278 to receive and return approved SA transactions. KePRO uses a proprietary DMAS format for electronic SA transactions. Also not used are the related X12 transactions listed.
Business Process Steps	1. **START:** Receive service authorization request from authorized provider. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax	KePRO does not use a 278 to receive and return approved SA transactions. KePRO uses a proprietary DMAS format for electronic SA transactions. Also not used are the related X12 transactions listed.

CM Authorization Determination		
	Authorize Service	
Item	**Details**	**DMAS Differences/Comments**
	criteria and requestor has completed all required fields. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. 3. Validate that the provided information is authentic. 4. Assign a tracking number. 5. Prioritize Service Authorization Request. 6. Validate the following: 7. Member eligibility – for social service model, this entails assessing member's health, functional, and socio-economic status 8. Requesting and servicing providers 9. Service coverage and referral requirements 10. Diagnosis code 11. Procedure code/or procedure groupings 12. Check for medical or functional necessity and appropriateness. 13. Check against current service authorizations for duplicates. 14. Validate completeness of supporting	Alternate Path for Out-of-State service approvals does not include all steps shown in the Business Process Steps. Pharmacy service authorizations are interfaced with MMIS and are done real time and VA must respond to all SAs within 24 hours.

CM Authorization Determination		
	Authorize Service	
Item	**Details**	**DMAS Differences/Comments**
	documentation. 15. Deny based on insufficient/erroneous information or authorization for service not medically necessary. Go to step 13. 16. Suspend the authorization request based on need for additional information. Go to step 13. 17. Approve service authorization request (this includes approved with modifications. 18. Send alert to send service authorization to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. 19. **END:** Send alert to notify member and requesting provider of service authorization determination. <u>Alternate Path:</u> For the authorization of some services, States may use the post-approval rather than the prior authorization business process. The post-approval business process includes all steps listed above, but process executes in a different order depending on state rules.	
Shared Data	Member data store including demographic information Provider data store including provider network Information Health Information Exchange (HIE) data store including health information, clinical record, and clinical data Plan data store including health benefits information Claims data store including adjudication information	No data received from HIE for VA business process.
Predecessor	**Receive Inbound Transaction**	Process Encounter Business Process is not associated with

CM Authorization Determination		
	Authorize Service	
Item	**Details**	**DMAS Differences/Comments**
	Process Claim ***Process Encounter***	SAs for VA
Successor	**Send Outbound Transaction** ***Process Claim*** ***Process Encounter*** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Submit Electronic Attachment***	Process Encounter and Submit Electronic Attachment business processes are not associated with SAs for VA.
Constraints	The authorize service request information will conform to the format and content in accordance with state-specific reporting requirements, e.g., using a HIPAA Transaction Standard Companion Guide.	
Failures	• The SMA receives incomplete service authorization request. • Requestor (provider) is not eligible for enrollment or does not have authority to make service authorization request for particular service. • Member is not eligible for services.	MMIS, KePRO, and Pharmacy authorization edits may prevent an authorization request from being approved.
Performance Measures	• Time to complete the process: e.g., Real Time response = within_____seconds, Batch Response = within ___hours • Accuracy with which service authorizations are approved or denied = ___ % • Consistency of decisions in approving or denying service authorizations =____%	**Pharmacy:** Service Authorizations are to be responded 2 within 24 hours of receipt. Accuracy is 100%. Consistency is 100%. Error rate is 0%. **DBHDS:** DBHDS does not track

CM Authorization Determination		
Authorize Service		
Item	**Details**	**DMAS Differences/Comments**
	• Error rate = _____% or less	timeliness. **KEPRO:** Time to complete the process: the batch process occurs daily at 6 am, 10.30 am, and 5 pm 7 days per week Additionally, DMAS imposes specific time frames for the service auth contractor to complete reviews, and post to MMIS successfully. **Accuracy:** Traditional Services: overall for 2014 fiscal year 95%; Non-Traditional Services: overall for 2014 fiscal year 100%; Overall Traditional and Non-Traditional combined for fiscal year 2014 98% **Consistency:** Traditional Services: overall for 2014 fiscal year 95%; Non-Traditional Services: overall for 2014 fiscal year 100%; Overall Traditional and Non-Traditional combined for fiscal year 2014 98% **Error rate:** DMAS monitors a small sample of cases each month, so error rate allowed is 5%. Given numbers from fiscal year 2014, KEPRO's error rate is 2%. **Provider Satisfaction** – 79% as evidenced by the Provider Satisfaction Survey. 79%

3.2.2.2.2 As-Is Assessment

The overall rating for the Authorize Service business process is '2.' Service authorizations are handled internally by DMAS and by its contractors, for example Magellan, DBHDS, KePRO, Provider Synergies, and Logisticare.

Other items noted in the As-Is assessment were:

- The DMAS EPSDT business unit performs some internal service authorizations.
- A post-approval review process is performed as part of an audit function and not a normal standard business process incorporated into MMIS.
- Pharmacy service authorizations are to be responded to within 24 hours of receipt.
- DMAS does not use the X12 278 transaction for this business process

3.2.2.2.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Authorize Service business process:

- Utilize Health Information Exchange (HIE) data store in the process where appropriate.
- Review all of the areas that require service authorizations to identify opportunities for standardization of authorization processes and further automation where appropriate.
- Establish meaningful metrics to track the timeliness, accuracy, consistency and error rate in the areas that currently do not capture these metrics.

3.2.2.2.4 Scorecard

The following scorecard was compiled for the Authorize Service business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CM - Authorization Determination Authorize Service	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		

Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.2.2.3 Authorize Treatment Plan

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Authorize Treatment Plan business process.

3.2.2.3.1 Business Process Model

The Authorize Treatment Plan business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CM Authorization Determination		
Authorize Treatment Plan		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Authorize Treatment Plan*** business process encompasses both a prior authorization and post-approved treatment plan. The State Medicaid Agency (SMA) uses the Authorize Treatment Plans primarily in the care coordination setting where the care management team assesses the member's needs,	ID and DD Waiver (DBHDS) have treatment plans process within their processes for DMAS use and information... The Prior Auth Utilization

CM Authorization Determination		
Authorize Treatment Plan		
Item	**Details**	**DMAS Differences/Comments**
	decides on a course of treatment, and completes the treatment plan. **NOTE:** MITA contains three (3) different authorization business processes: 1. ***Authorize Service*** – the standard process of prior authorization of services. 2. ***Authorize Treatment Plan*** – the approval of a treatment plan prepared by a care management team in a care management setting. 3. ***Authorize Referral*** – specifically the approval of a referral to another provider, requested by a primary care physician. A treatment plan prior-authorizes the named providers or provider types and services or category of services. The SMA prior authorizes individual providers for the service or category of services, and they do not have to submit their own prior authorizations or service requests. A treatment plan typically is a schedule of medical, therapeutic, and /or psychological procedures and appointments that spans a length of time designed to restore a patient's specific health condition. In contrast, the SMA limits an individual service request, primarily associated with fee-for- services payment, to focus on a specific visit, services, or products (e.g., a single specialist office visit, approval for a specific test or particular piece of Durable Medical Equipment (DME)). The prior authorized treatment plan generally begins with the receipt of an authorize treatment plan request from the care management team. The SMA staff then evaluates it based on urgency, state priority requirements, and type of service/taxonomy (speech, physical therapy, home health, behavioral, social), and validates key information, and ensures that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, staff approves, modifies, suspends for additional information or denies the request. Business process sends an alert to ***Manage Case Information*** business process. A post-approved treatment plan is an audit function that reviews suspended or paid claims to ensure the services were appropriate and in accordance with	Review Unit (PAUR) performs post payment reviews to audit treatment plans from DBHDS and Magellan. KePRO gets the treatment plan for the DD Waivers in order to do the Service Authorizations for DD Waivers. For Tech Waivers, the doctor's orders are the treatment plan. Home Health, Rehab, PACE all have a process to generate and obtain approved treatment plans. Magellan for behavioral health services also has process to set up and approve treatment plans based on DMAS contract. In VA, the approved treatment plan may still require specific service authorizations based on services included in treatment plan.

CM Authorization Determination		
Authorize Treatment Plan		
Item	**Details**	**DMAS Differences/Comments**
	the treatment plan.	
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive treatment plan request from Health Information Exchange (HIE) via Accredited Standards Committee (ASC) X12 278 Health Care Services Review Request and Response transaction. • Receive treatment plan request from requestor via ASC X12 278 Health Care Services Review Request and Response transaction. Environment-based Trigger Events to include but not limited to: • Care manager submits a request for treatment plan authorization. • Provider submits a request for treatment plan authorization in accordance with state policy. • Provider submits additional information for existing treatment plan request.	X12 278 transactions are not used for VA.
Result	• The SMA sends the authorization response to requestor. • Alert sent with treatment plan information to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA).	X12 278 transactions are not used for VA.

CM Authorization Determination		
Authorize Treatment Plan		
Item	**Details**	**DMAS Differences/Comments**
	• Alert sent to ***Manage Applicant and Member Communication*** to send notification of authorized treatment plan response. • Alert sent to ***Manage Case Information*** business process for purpose of responding to provider or member inquiry about the status of a treatment plan authorization or member filing of a grievance or an appeal about treatment authorization response. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request for Treatment Plan authorization for authorized provider or care manager. 2. Assign a tracking identifier. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 4. Validate that the provided information is authentic. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. 5. Prioritize authorize treatment plan request. 6. Validate the following: 7. Member eligibility 8. Eligibility for requesting and servicing providers	

CM Authorization Determination		
Authorize Treatment Plan		
Item	**Details**	**DMAS Differences/Comments**
	9. Service coverage and plan of treatment requirements 10. Diagnosis code 11. Procedure codes/or procedure groupings 12. Check for medical, social, and behavioral appropriateness. 13. Check against currently authorized treatment plans and service requests for duplication. 14. Coordinate services (check for duplicates) across programs and systems. 15. Validate completeness of supporting documentation. 16. Deny based on insufficient/erroneous information or treatment plan identifying services not medically, socially, and/or behaviorally necessary. Go to step 14. 17. Suspend the treatment plan request based on the need for additional information. Send a request for additional information. Go to step 14. 18. Approve plan of treatment request (this includes approved with modifications) and send approval response information to requesting parties. 19. Send alert to send treatment plan authorization to requestor via ASC X12 278 Health Care Services Review Request and Response transaction. 20. **END:** Send alert to notify member, care manager, and provider of authorization determination.	
Shared Data	Member data store including demographic information Provider data store including provider network Information Health Information Exchange (HIE) data store including health information, clinical record, and clinical data	HIE information is not used for VA. Add to the list: Member's medical records.

CM Authorization Determination		
Authorize Treatment Plan		
Item	**Details**	**DMAS Differences/Comments**
	Plan data store including health benefits information Claims data store including adjudication information	
Predecessor	**Receive Inbound Transaction** ***Establish Case*** ***Manage Case Information*** ***Manage Treatment Plan and Outcomes***	We don't do Manage Treatment Plan and Outcomes with the exception of DBHDS and Community Nursing Provider.
Successor	**Send Outbound Transaction** ***Manage Case Information*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Submit Electronic Attachment*** ***Manage Treatment Plan and Outcomes***	Electronic Attachment Process not available in VAMMIS. KePRO does use Electronic Attachment Process.
Constraints	The authorize treatment plan information will conform to the format and content in accordance with state-specific reporting requirements, e.g., using a HIPAA Transaction Standard Companion Guide.	Form 475 from CMS used
Failures	• Invalid beneficiary, invalid provider, invalid service, invalid dates, conflicting diagnosis, and treatment plan.	
Performance Measures	• Time to complete the process: e.g., Real Time response = within___ seconds, Batch Response = within ___hours • Accuracy with which the SMA approves treatment plan = ___% • Consistency of decisions in approving or denying treatment plans = ___%	

CM Authorization Determination		
Authorize Treatment Plan		
Item	Details	DMAS Differences/Comments
	• Error rate = ___% or less	

3.2.2.3.2 As-Is Assessment

The overall rating for the Authorize Treatment Plan business process is '2.' This process is applicable to Home Health, Rehab, PACE, ID and DD Waivers, and behavioral health services. For Tech Waivers, the doctor's orders are the treatment plan. EPSDT case based authorizations can fall into both categories depending upon the service being authorized.

Other items noted in the As-Is assessment were:

- The Prior Authorization Utilization Review Unit (PAUR) performs post payment reviews to audit treatment plans from DBHDS and Magellan.
- The approved treatment plan may still require specific service authorizations based on services included in treatment plan.
- X12 278 transactions are not used by DMAS
- The Health Information Exchange (HIE) data store including health information, clinical record, and clinical data is not used in Virginia for this process.

3.2.2.3.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Authorize Treatment Plan business process:

- Utilize Health Information Exchange (HIE) data store in the process where appropriate.
- Review all of the areas that require treatment plan authorizations to identify opportunities for standardization of related processes and further automation where appropriate.
- Establish service level goals and meaningful metrics to track the timeliness, accuracy, consistency and error rate in the areas that currently do not capture these metrics.

3.2.2.3.4 Scorecard

The following scorecard was compiled for the Authorize Treatment Plan business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CM - Authorization Determination Authorize Treatment Plan	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.3 CONTRACTOR MANAGEMENT

OVERVIEW

The Contractor Management business area accommodates a SMA that has managed care contracts or a variety of outsourced contracts. The Contractor Management business area has a common focus on Medicaid contractors (e.g., managed care, at-risk mental health or dental care, primary care physician), is responsible for contractor data store, and uses business processes that have a common purpose (e.g., fiscal agent, enrollment broker, Fraud Enforcement Agency, and third-party recovery).

The Contractor Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.3-1.

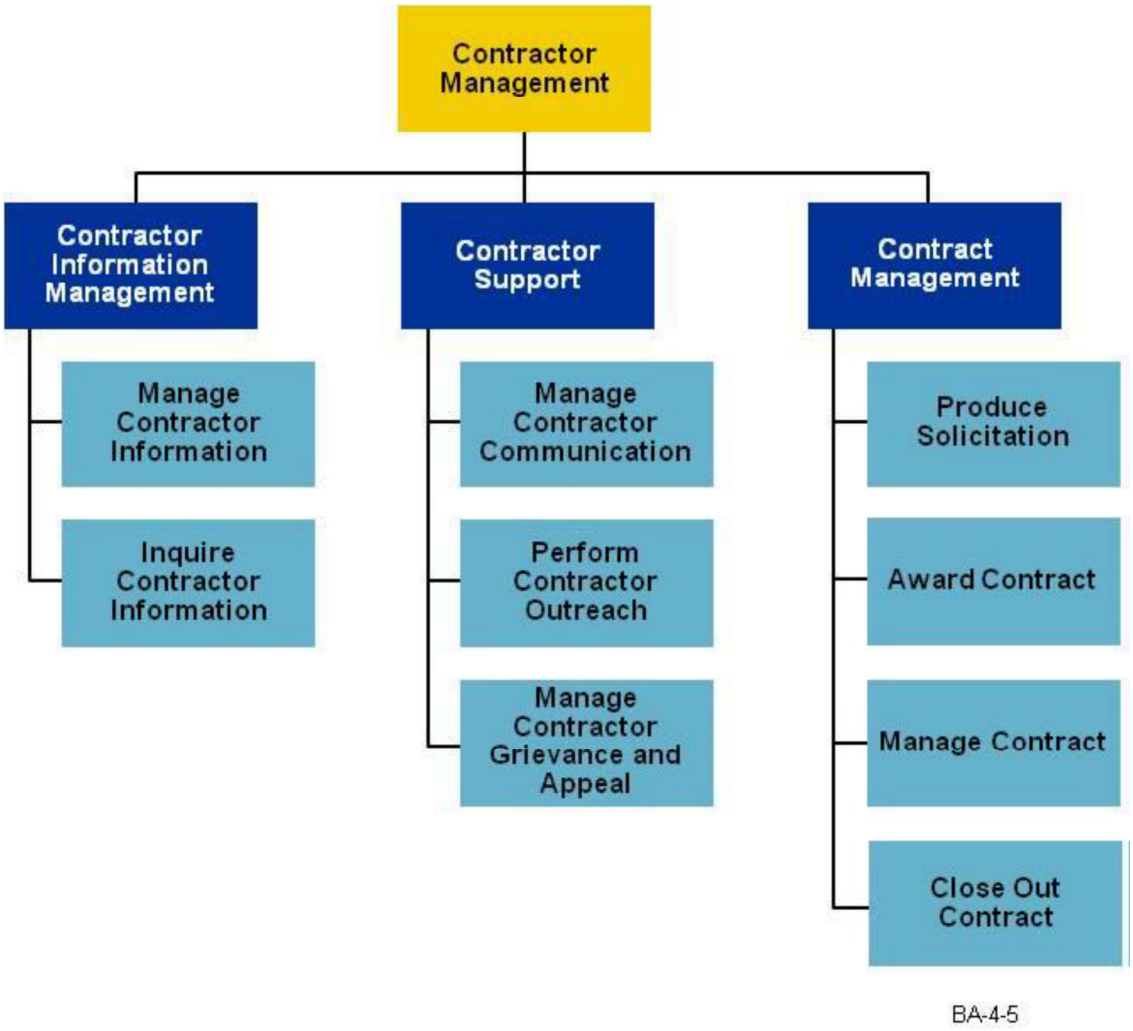


Figure 3.3-1

BUSINESS ARCHITECTURE PROFILE

The Contractor Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Contractor Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Manage Contractor Information		As-Is	To-Be		
Inquire Contractor Information		As-Is	To-Be		
Manage Contractor Communication		As-Is	To-Be		
Perform Contractor Outreach		As-Is	To-Be		
Manage Contractor Grievance and Appeal		As-Is	To-Be		
Produce Solicitation		As-Is	To-Be		
Award Contract		As-Is	To-Be		
Manage Contract		As-Is	To-Be		
Close Out Contract		As-Is	To-Be		

3.3.1 Contractor Information Management

As shown in Figure 3.3-1, the Contractor Information Management business category is made up of two business processes:

- Manage Contractor Information
- Inquire Contractor Information

Details regarding the assessment of each Contractor Management business process follow.

3.3.1.1 Manage Contractor Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the [Business Process Y] business process.

3.3.1.1.1 Business Process Model

The Manage Contractor Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contractor Information Management		
Manage Contractor Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Contractor Information*** business process is responsible for managing all operational aspects of the Contractor (e.g., managed care, at-risk mental health or dental care, primary care physician, Recovery Audit Contractor (RAC)) data store. This business process receives a request for addition, deletion, or modification to Contractor information, validates the request, and applies the instruction. **NOTE**: Requires billing agents, clearinghouses, or other alternate payees (as defined by the Secretary) to register with Medicaid agency.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive request to create, inquire, delete, or modify contractor information from authorized individuals via email, mail, facsimile, telephone or web. • Receive request to verify contractor information from authorized external parties.	
Result	• The State Medicaid Agency (SMA) creates, inquires on, deletes, or modifies contractor information. • Alert sent to notify Health Insurance Marketplace of provider network modification information. • Alert sent to notify insurance affordability program of provider network modification. • Alert to Manage Contractor Communication business process to notify contractor of relevant modifications. • Tracking information as needed for measuring performance and business	DMAS does not notify the Health Insurance Marketplace. DMAS does not notify the insurance affordability program.

CO Contractor Information Management		
	Manage Contractor Information	
Item	**Details**	**DMAS Differences/Comments**
	activity monitoring.	
Business Process Steps	1. **START:** Receive request from authorized individuals or agencies to create, inquire, delete or modify contractor information. 2. Agency logs request for contractor information. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 4. Validate authorization of requestor to acquire contactor information. 5. Find appropriate contractor. 6. Create, inquire, delete or modify relevant contractor information. 7. Send alert to notify Health Insurance Marketplace of provider network modification. 8. Send alert to notify insurance affordability program of provider network modification. 9. Send alert to Manage Contractor Communication business process to notify provider of relevant modifications. 10. **END**: The SMA creates, inquires on, deletes, or modifies contractor information.	#7 and #8 are not applicable

CO Contractor Information Management		
	Manage Contractor Information	
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Contractor data store including contract information	In addition to utilizing an in-house spreadsheet for listing and monitoring contract information, DMAS also uses the Commonwealth's eVA system as a repository for procurement data. It is used by all state agencies in the Commonwealth
Predecessor	***Manage Contract*** ***Close Out Contract***	
Successor	***Perform Contractor Outreach*** ***Manage Contractor Grievance and Appeal*** ***Manage Contractor Communication*** ***Manage Data***	
Constraints	Information requirements and data structures for the contractor data store may differ from state to state.	Our business processes conform to the VA Public Procurement Act (VPPA) and the Agency Procurement and Surplus Property Manual (APSPM), see eVA website.
Failures	• The SMA cannot find contractor information. • The SMA cannot respond to a request (e.g., cannot change tax ID because it would change the contracted entity). • Validation failed (e.g., address is not a legal address). • Contract provides incomplete information (e.g., missing required information	

CO Contractor Information Management		
	Manage Contractor Information	
Item	**Details**	**DMAS Differences/Comments**
	elements).	
Performance Measures	• Timeliness to complete process = within days • Accuracy with which changes are applied = 100% • Consistency of decisions and disposition =100 • Error rate = 0 % or less	• The timeliness is variable by contract depending on the contract as well as information request. • 100% • 100% • 0%

3.3.1.1.2 As-Is Assessment

The overall rating for the Manage Contractor Information business process is '2.' The process uses a mix of manual, automatic, and electronic transactions.

Other items noted in the As-Is assessment were:

- DMAS does not notify the Health Insurance Marketplace of provider network modification information.
- DMAS does not notify the insurance affordability program of provider network modification information.
- In addition to utilizing an in-house spreadsheet for listing and monitoring contract information, DMAS also uses the Commonwealth's eVA system as a repository for procurement data. It is used by all state agencies in the Commonwealth
- DMAS business processes conform to the VA Public Procurement Act (VPPA) and the Agency Procurement and Surplus Property Manual (APSPM), see eVA website.

3.3.1.1.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Manage Contractor Information

business process:

- Modify the business process to notify the Health Insurance Marketplace and the insurance affordability program of contractor network modifications.
- Automate the collection and storage of contractor data where practical.
- Store contractor data in a centralized repository that is accessible to internal stakeholders.
- Produce an audit trail of contractor decisions 100% of the time.
- Collaborate with other intrastate agencies, other states and federal entities to develop and adopt national standards.
- Collaborate with other intrastate agencies, other states and federal entities to develop and share reusable business services.
-

3.3.1.1.4 Scorecard

The following scorecard was compiled for the Managed Contractor Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contractor Information Management Manage Contractor Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		

Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.3.1.2 Inquire Contractor Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for Inquire Contractor Information business process.

3.3.1.2.1 Business Process Model

The Inquire Contractor Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contractor Information Management		
Inquire Contractor Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Inquire Contractor Information*** business process receives requests for contract (e.g., managed care, at-risk mental health or dental care, Primary Care Physician (PCP)) verification from authorized providers, programs or business associates, performs the inquiry, and prepares the response for the **Send Outbound Transaction**.	The only time we receive inquiries is FOIA requests.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive contract verification request from Receive Inbound Transaction.	

CO Contractor Information Management		
	Inquire Contractor Information	
Item	**Details**	**DMAS Differences/Comments**
Result	• Contract verification response sent to requestor. • Tracking information as needed for measuring performance and business activity monitoring.	Contract verification response sent to requestor. Requests of this type are channeled through the FOIA office
Business Process Steps	1. **START**: Receive contract verification request. 2. Validate information submitted is correct and as complete as possible. 3. Information complies with syntax criteria and requestor has completed all required fields. 4. Validate that the provided information is authentic. 5. Agency logs contract verification request. 6. Determine request status as initial or duplicate. 7. Query contractor data store for requested information. 8. Agency logs contract verification response. 9. **END**: Send contract verification response to requestor.	
Shared Data	Contractor data store including contract information	
Predecessor	***Receive Inbound Transaction***	All requests come through the FOIA office.
Successor	**Send Outbound Transaction** ***Manage Contractor Information***	Manage Contractor Information - Not

CO Contractor Information Management		
Inquire Contractor Information		
Item	**Details**	**DMAS Differences/Comments**
		applicable
Constraints	The State Medicaid Agency (SMA) determines what information to share	The information can be shared as allowed under FOIA and the Public Procurement Act and Agency Procurement Regulations.
Failures	• The SMA is unable to find contractor information. • The SMA is unable to respond to a request. • Validation failed. • Requestor provides incomplete information (e.g., missing required information elements).	The SMA is unable to find contractor information. NA The SMA is unable to respond to a request. NA Validation failed. NA Requestor provides incomplete information (e.g., missing required information elements). NA No failures at DMAS
Performance Measures	• Time to verify Contractor information and generate response • information: e.g., Real Time response = within seconds, • Batch Response = within hours • Response Accuracy =100% • Error rate = zero % or less	Timelines are set by FOIA, maximum 5 days.

3.3.1.2.2 As-Is Assessment

The overall rating for the Inquire Contractor Information business process is '2'. Data Access is available

only during business hours.

Other items noted in the As-Is assessment were:

- DMAS determines the type of information that can be shared. The information can be shared as allowed under FOIA and the Public Procurement Act and Agency Procurement Regulations.
- DMAS sends outbound transactions as requests are channeled in through FOIA office.

3.3.1.2.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Inquire Contractor Information business process:

- When requests for information are received, automate the workflow to provide information that can be shared as allowed under FOIA and the Public Procurement Act and Agency Procurement Regulations.
- Reduce the timeline for responses through automation.
- Make information available via the DMAS web portal to the extent allowed by the Public Procurement Act and Agency Procurement Regulations.
- Store and transfer requested inquiry documents electronically.
- Collaborate with other intrastate agencies and other entities to develop and share reusable business services.
- Establish meaningful metrics to track the accuracy and timeliness in which requests for information are handled.

3.3.1.2.4 Scorecard

The following scorecard was compiled for the Inquire Contractor Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contractor Information Management Inquire Contractor Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	1	3

Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.3.2 Contractor Support

As shown in Figure 3.3-1, the Contractor Support business category is made up of three business processes:

- Manage Contractor Communication
- Perform Contractor Outreach
- Manage Contractor Grievance and Appeal

Details regarding the assessment of each Contractor Support business process follow.

3.3.2.1 Manage Contractor Communication

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Contractor Communication business process.

3.3.2.1.1 Business Process Model

The Manage Contractor Communication business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contractor Support		
	Manage Contractor Communication	
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Contractor Communication*** business process receives requests for information, appointments, and assistance from contractors (e.g., managed care, at- risk mental health or dental care, primary care physician) such as inquiries related to modifications in Medicaid Program policies and procedures, introduction of new programs, modifications to existing programs, public health alerts, and contract amendments, etc. This business process includes the log, research, development, approval, and delivery of routine or ad hoc messages. The State Medicaid Agency (SMA) communications a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). **NOTE:** The ***Manage Contractor Communication*** business process handles current contractors by providing assistance and responses to individual entities, i.e., bi-directional communication. The ***Perform Contractor Outreach*** business process targets both prospective and current contractor populations for distribution of information regarding programs, policies, and other issues. Other examples of communications include: • Pay for performance communications – performance measures could affect capitation payments or other reimbursements. Incentives to improve encounter information quality and submission rates.	This process does not involve Providers.
Trigger	Interaction-based Trigger Events to include but not limited to: • Receive request from other business	

CO Contractor Support		
	Manage Contractor Communication	
Item	**Details**	**DMAS Differences/Comments**
Event	processes to develop and produce communications for contractors such as notifications from ***Manage Contractor Information*** business process. Environment-based Trigger Events to include but not limited to: • Receive an inquiry from contractor. • Request to send information packages. • Request for assistance, such as a request for training or modify contractor information. • Periodic timetable (e.g., monthly) is due to send information (e.g., within 24 hours of new contract award and periodic communications such as newsletters or other agency communications).	
Result	• Contractor receives appropriate assistance, communications, and/or information packages. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request for communication. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. 4. Agency logs request for communication. 5. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web, or EDI.	#4 and #9: Communications are not logged but e-mails are maintained

CO Contractor Support		
	Manage Contractor Communication	
Item	**Details**	**DMAS Differences/Comments**
	6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).	
Shared Data	Contractor data store including contract information Plan data store including health benefit information	
Predecessor	***Receive Inbound Transaction*** **Award Contract Manage Contract** **Close Out Contract** **Manage Contractor Information** **Inquire Contractor Information** **Manage Contractor Grievance and Appeal** **Maintain State Plan** **Manage Health Plan Information** **Manage Health Benefit Information** **Manage Performance Measures**	
Successor	**Send Outbound Transaction** ***Manage Performance Measures***	Performance information is not maintained

CO Contractor Support		
	Manage Contractor Communication	
Item	**Details**	**DMAS Differences/Comments**
Constraints	• Communications will vary by state, by type of contractor, and by type of communication. • Contractor may have communication barriers such as lack of internet or phone access. Contractor is unable to access needed or requested information.	
Failures	• The SMA is unable to provide linguistically, culturally, or competency appropriate information. • Delivery failures due to erroneous contact information or lack of contact information.	
Performance Measures	• Time to complete response: By phone minutes; by email hours; by mail _____ • Accuracy of communications = % • Communications successfully delivered = %	Performance information is not maintained 100% 100%

3.3.2.1.2 As-Is Assessment

The overall rating for the Manage Contractor Communication business process is '2.' DMAS's primary method of communication for this particular business process is though e-mails.

Other items noted in the As-Is assessment were:

- DMAS does not log communication but emails are maintained for tracking purpose.
- Performance Information is not maintained.
-

3.3.2.1.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Manage Contractor Communication business process:

- Develop a contractor communication logging procedure.
- Standardize communication and eliminate manual steps where possible.
- Identify the most common information that is communicated routinely to contractors and make it available for self-service on the DMAS web portal.
- Establish meaningful metrics to track the accuracy and timeliness in which contractor communications are handled.

3.3.2.1.4 Scorecard

The following scorecard was compiled for the Managed Contractor Communication business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contractor Support ***Manage Contractor Communication***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	1	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		

Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.3.2.2 Perform Contractor Outreach

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Perform Contractor Communication business process.

3.3.2.2.1 Business Process Model

The Perform Contractor Outreach business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contractor Support		
Perform Contractor Outreach		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Perform Contractor Outreach*** business process is responsible for sending information such as public health alerts, new programs, and/or modifications in the Medicaid Program policies and procedures. For prospective contractors (e.g., managed care, at-risk mental health or dental care, primary care physician), States Medicaid Agency (SMA) develops contractor outreach information for prospective contractors identified by analyzing Medicaid business needs. For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives.	

CO Contractor Support		
Perform Contractor Outreach		
Item	**Details**	**DMAS Differences/Comments**
	The SMA communicates contractor outreach information by a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). The SMA produces, distributes, tracks, and archives all contractor outreach communications according to state rules.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Executive Management decision to: o Fill gaps in health care service and administrative coverage. o Solicit updated/new administrative and technical functions. o Introduce new programs requiring new types of health or administrative service. o Change to existing policies and procedures. o Respond to critical need in a specific target population. o Identify new populations in need of service (e.g., new immigrant communities). o State transition-based trigger events: o Alert received from Manage Health Plan Information business process of addition or modification. o Alert received from Manage Health Benefit Information business process of addition or modification.	
Result	• Agency produces outreach communications (e.g., mailing brochure, web page, email, kiosk, radio, billboard, and TV advertisements) and distributes to targeted contractors. Agency may also conduct face-to-face meetings. • Tracking information as needed for measuring performance and business activity monitoring.	

CO Contractor Support		
Perform Contractor Outreach		
Item	**Details**	**DMAS Differences/Comments**
Business Process Steps	1. **START:** Receive request for outreach materials or communication. 2. Target population identified and defined by analyzing information, performance measures, feedback from community, and policy directives. 3. Approve, deny, or modify decisions to develop outreach communications. 4. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web or EDI. 5. Determine performance measures. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate)	
Shared Data	Contractor data store including provider network information Plan data store including policy information Health Benefits data store including benefit package and benefits information Performance Measures data store including	NO CAPHS External quality review services-

CO Contractor Support		
Perform Contractor Outreach		
Item	**Details**	**DMAS Differences/Comments**
	agency's objectives (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) information)	
Predecessor	***Manage Performance Measures*** ***Identify Utilization Anomalies*** ***Maintain State Plan*** ***Manage Health Plan Information*** *Manage Health Benefit Information*	
Successor	***Send Outbound Transaction*** ***Manage Contractor Communication*** ***Manage Performance Measures***	
Constraints	Communications and information packages will address the needs of the targeted population. Materials will be linguistically and culturally appropriate, legally compliant, appropriate to the targeted group, and meet financial guidelines (re: cost to produce and distribute). Other constraints may be agency priority, availability of resources, and accuracy of contractor contact information. Contractor may have communication barriers such as lack of internet or phone access. Contractor is unable to access needed or requested information.	
Failures	Unable to identify target population based on desired criteria. • Management denies permission for	

CO Contractor Support		
Perform Contractor Outreach		
Item	**Details**	**DMAS Differences/Comments**
	outreach activity. • The SMA cancels health plan or health benefit. • Delivery failures due to erroneous contact information.	
Performance Measures	• Time to complete process of developing outreach materials = 30 days • Accuracy of outreach materials = 100 % • Successful delivery rate to targeted individuals = 100 % • Effectiveness of the communication – Outreach results in achieving specified goals – 100%	

3.3.2.2.2 As-Is Assessment

The overall rating for the Perform Contractor Outreach business process is '2'. The process is a mix of electronic transactions and manual responses.

One other item noted in the As-Is assessment was:

- DMAS does not use CAPHS as Performance Measures data store to include agency's objectives

3.3.2.2.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Perform Contractor Outreach business process:

- Strive to expand number of contractors to enrolled in eVA to receive automated notifications when DMAS posts a new RFI/RFP.
- Standardize and create reusable outreach materials when practical.
- Eliminate manual steps where possible.

- Make outreach materials available for self-service downloads on the DMAS web portal.
- Establish meaningful metrics to track the accuracy, timeliness, and effectiveness of provider outreach materials.

3.3.2.2.4 Scorecard

The following scorecard was compiled for the Perform Contractor Outreach business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contractor Support ***Perform Contractor Outreach***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3

Performance Measure	
Supporting Evidence Reference	

3.3.2.3 Manage Contractor Grievance and Appeal

The following sections provide the business process model, a summary of the As-Is and To-Be assessments and the Business Architecture scorecard for the Manage Contractor Grievance and Appeal business process.

3.3.2.3.1 Business Process Model

The Manage Contractor Grievance and Appeal business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contractor Support		
Manage Contractor Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Contractor Grievance and Appeal*** business process handles contractor (e.g., managed care, at-risk mental health or dental care, primary care physician) appeals* of adverse decisions or communications of a grievance. The ***Manage Contractor Communication*** business process initiates a grievance or appeal. The State Medicaid Agency (SMA) logs and tracks the grievance or appeal; it triages to appropriate reviewers; it researches it; it may request additional information; it schedules and conducts a hearing in accordance with legal requirements; and it makes a ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the contractor's information. Agency formally notifies contractor of the decision. This business process supports the ***Manage Performance Measures*** business process by providing information about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This information used to discern program improvement opportunities, which may reduce the issues that give rise to grievances	

CO Contractor Support		
	Manage Contractor Grievance and Appeal	
Item	**Details**	**DMAS Differences/Comments**
	and appeals. Based on the appeal business process, if a contractor wins an appeal that impacts or clarifies a Medicaid State Plan, health plan, or health benefit this process sends that information to ***Maintain State Plan, Manage Health Plan Information*** or ***Manage Health Benefit Information*** business processes to modify the relevant policy or procedure. Disposition could result in legislative change requirements that will be communicated to lawmakers. **NOTE:** States may define grievance and appeal differently, perhaps because of state laws. *This business process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal, for example, when agency does not award a contract to contractor. Protests received from prospective contractors are addressed in the ***Award Contract*** business process	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive grievance or appeal alert from Manage Contractor Information business process. • Receive grievance or appeal alert from Award Contract business process.	
Result	Alert to send notification of final disposition of grievance or appeal to the contractor. • If applicable, alert sent to Establish Compliance Incident business process for further investigation. • If applicable, alert sent to Maintain State Plan business process to modify the relevant policy or procedure.	

CO Contractor Support		
Manage Contractor Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
	• If applicable, alert sent to Manage Health Plan Information business process to modify the relevant policy or procedure. • If applicable, alert sent to Manage Health Benefit Information business process to modify the relevant policy or procedure. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. START: Receive grievance or appeal. 2. Agency logs grievance or appeal. 3. Validate information submitted is correct and as complete as possible. 4. Information complies with syntax criteria and submitter has completed all required fields. Validate that the provided information is authentic. 5. If appropriate, request additional documentation. 6. Determine status as initial, second, expedited or other status as designated by the state. 7. Triage to appropriate personnel for review. 8. Perform research and analysis. 9. If appropriate, schedule hearing within required time limit. 10. If appropriate, conduct hearing within required time limit. 11. Determine disposition. 12. If applicable, send alert to ***Establish Compliance Incident*** business process for further investigation. 13. If applicable, alert sent to ***Maintain State Plan*** business process to modify the relevant policy or procedure. 14. If applicable, alert sent to ***Manage Health Plan Information*** business process to modify the relevant policy or procedure. 15. If applicable, alert sent to ***Manage Health Benefit Information*** business process to modify the relevant policy or procedure. 16. **END:** Send alert to notify contractor of disposition	Contractor schedules hearing Hearing depends on response for the protest.

CO Contractor Support		
Manage Contractor Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
	determination. **NOTE:** Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.	
Shared Data	Contractor data store including provider network and contract information Grievance and Appeal data store including case history information Claims data store including claims and premium Information	
Predecessor	***Manage Contractor Information*** ***Award Contract***	
Successor	***Manage Contractor Communication*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Performance Measures*** ***Establish Compliance Incident***	
Constraints	States have different requirements for evidence and the process for conducting the grievance/appeals cases. They have different rules for assigning outcome status and state specific consequences.	
Failures	Grievance and appeal supporting documentation is incomplete. • The SMA cannot schedule or conduct hearing in the required period. • Contractor withdraws grievance or appeal. • Unable to process grievance or appeal per federal or state law.	

CO Contractor Support		
Manage Contractor Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
Performance Measures	• Time to complete process: normal grievance/appeal = 10 days; second appeal = 10days; expedited appeal = hours • Accuracy of decisions = 100 % • Consistency of decisions and disposition = 100 % • Error rate = 0% or less	Contractor has 10 days to file protest, DMAS has 10 days to respond Contractor has 10 days to make 2nd appeal. No expedited appeal

3.3.2.3.2 As-Is Assessment

The overall rating for the Manage Contractor Grievance and Appeal business process is '2'. The process is a mix of manual and electronic record keeping.

Other items noted in the As-Is assessment were:

- Contractor schedules hearing. Hearing depends on response for the protest.
- Contractor has 10 days to file protest, DMAS has 10 days to respond, Contractor has 10 days to make second appeal.
- DMAS does not do expedited appeals.

3.3.2.3.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Manage Contractor Grievance and Appeal business process:

- Identify areas of the process that can be automated and/or streamlined.
- Strive to conduct the majority of activities electronically, except where federal and state regulations require paper documents.
- Scan documents for capturing electronic information and store in a central data repository that is accessible to stakeholders.
- Collaborate with other state agencies and entities to adopt national standards and to develop and share reusable business services.
- Implement standardized business rules and utilize them to automate decision-making where practical.
- Publish program business rules on the DMAS web portal so that contractors can discern whether their grievances or appeals have merit.
- Analyze the types of grievances and the associated root causes so that improvements can be

made to the program and the number of grievances can be reduced.

- Review best practices at other states to see if expedited appeals might be implemented in Virginia.
- Establish meaningful metrics to track the accuracy, timeliness, and effectiveness of the grievance and appeal business process.
-

3.3.2.3.4 Scorecard

The following scorecard was compiled for the Manage Contractor Grievance and Appeal business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contractor Support ***Manage Contractor Grievance and Appeal***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		

Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.3.3 Contract Management

As shown in Figure 3.3-1, the Contractor Support business category is made up of three business processes:

- Produce Solicitation
- Award Contract
- Manage Contract
- Close Out Contract

Details regarding the assessment of each Contract Management business process follow.

3.3.3.1 Produce Solicitation

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Produce Solicitation business process.

3.3.3.1.1 Business Process Model

The Produce Solicitation business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contract Management		
Produce Solicitation		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Produce Solicitation*** business process gathers requirements, develops a solicitation (e.g., Request for Information (RFI), Request for Quotation (RFQ), or Request for Proposals (RFP)), receives approvals for the solicitation, and releases for response.	
Trigger Event	Environment-based Trigger Events to include but not limited to:	

CO Contract Management		
	Produce Solicitation	
Item	**Details**	**DMAS Differences/Comments**
	• A scheduled date for re-procurement of contract is due. • Request by Executive Management to procure or re-procure a contract.	
Result	• The State Medicaid Agency (SMA) produces an Advance Planning Document (APD). • The SMA produces a solicitation for distribution. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive directive to procure or re-procure contract. 2. Gather requirements for services. 3. Determine if CMS requires an APD. a. Produce APD. b. Modify APD as directed. c. Receive approval for APD. 4. Develop solicitation for the services. 5. Receive internal (state) and federal approvals for solicitation. 6. Advertise solicitation. 7. **END:** The SMA releases solicitation for response.	

CO Contract Management		
	Produce Solicitation	
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Plan data store including policy information Health Benefit data store including benefit package and benefit information Not Applicable Contractor data store including provider network NA for provider network Manage Performance Measures data store including agency objectives and business activity Information Technology (IT) Plan	
Predecessor	***Manage Health Plan Information***	
Successor	***Award Contract***	
Constraints	Each state decides what types of contracts to procure. States engage in a wide range of contracts. Statutes that provide the legal framework for procurements govern all States. Each state's statutes are different from all other States. Business process steps differ from state to state.	
Failures	• The SMA loses funding for the procurement. • Insufficient responses to solicitation.	
Performance Measures	• Time to complete process =____months;____ • Accuracy of information =100% • Accessibility of information for creating solicitation =_____months; ____weeks Variable depending on the complexity of the solicitation • Consistency of decisions and disposition =100% • Error rate = _zero_% or less	

3.3.3.1.2 As-Is Assessment

The overall rating for the Produce Solicitation business process is '2.' The process requires the user to gather input through different sources stored in disparate systems. It is a combination of mostly manual process and publishing solicitation information on a website.

Other items noted in the As-Is assessment were:

- DMAS does not have a Health Benefit data store including benefit package and benefit information.
- DMAS does not have a Contractor data store that includes provider network.

3.3.3.1.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Produce Solicitation business process:

- Identify manual steps in the process and automate them wherever possible.
- Create a central Contractor data store that contains past RFP, RFI, and RFQ materials that can be used as a reference for future solicitations.
- Automate the business rules to the extent possible.
- Collaborate with other intrastate and entities to adopt national standards and to develop and share reusable business services.
- Establish meaningful metrics to track the accuracy, timeliness, and effectiveness of the Produce Solicitation business process.
-

3.3.3.1.4 Scorecard

The following scorecard was compiled for the Produce Solicitation business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contract Management Produce Solicitation	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3

Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.3.3.2 Award Contract

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Award Contract business process.

3.3.3.2.1 Business Process Model

The Award Contract business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contract Management

Award Contract		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Award Contract*** business process utilizes requirements, advanced planning documents, requests for information, request for proposal, and sole source documents to request and receive proposals, verify proposal content against Request for Proposal (RFP) or sole source requirements, apply evaluation criteria, designate contractor/vendor, post award information, entertain protests, resolve protests, negotiate contracts, and notify parties. In some States, this business process makes a recommendation of award instead of the actual award itself. **NOTE**: The State Medicaid Agency (SMA) requires billing agents, clearinghouses, or other alternate payee (as defined by the Secretary) to register.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive respondent's proposal or approval for sole source.	
Result	• Alert to send notification of award status to respondent. • The SMA negotiates contract with awarded contractor. • Tracking information as needed for measuring performance and business activity monitoring.	Virginia's procurement regulations require that we negotiate contract before we make the award.
Business Process Steps	1. **START:** Receive respondent's proposal (e.g., email, mail, web, or Electronic Data Interchange (EDI). 2. Conduct collection of contractor information. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and respondent has completed all required	Virginia's procurement regulations require that we negotiate contract before we make the award. This should be occur before item number 10 as required by eVA.

CO Contract Management		
Award Contract		
Item	**Details**	**DMAS Differences/Comments**
	fields for the type of contractor. 4. If applicable, request additional information. 5. Validate information provided is authentic (e.g., corporate status). 6. Validate contractor network, resources, and other requirements and obtain appropriate approvals (i.e., state, federal). 7. Assign identification to the respondent. 8. Verify proposal content against RFP or sole source requirements. 9. Apply evaluation criteria to respondent's proposal. 10. Make determination of awarded contractor. 11. Post award information. 12. Send alert to notify respondent of award results (e.g., award/recommend, deny, or continue negotiations). 13. If applicable, send alert to ***Manage Contractor Grievance and Appeal*** business process to receive protests and disposition protests. 14. **END:** Negotiate contract with	

CO Contract Management		
Award Contract		
Item	**Details**	**DMAS Differences/Comments**
	contractor, collect additional information required to complete a contract, negotiate, and assign rates or other form of payment	
Shared Data	Contractor data store including provider network and contract information	Excludes provider network for contract records retained in the Division of Budget and Contract Management at DMAS.
Predecessor	***Receive Inbound Transaction*** *Produce Solicitation*	
Successor	**Send Outbound Transaction** ***Manage Contractor Communication*** ***Manage Contract*** ***Manage Contractor Grievance and Appeal***	
Constraints	The Contractor application will accommodate the full range of contractor types.	
Failures	• Information does not comply with syntax criteria. • Not all required information provided. • Information provided not authenticated. • Parties are unable to negotiate contract (e.g., no agreement on rates). • The SMA loses funding.	

CO Contract Management		
Award Contract		
Item	**Details**	**DMAS Differences/Comments**
	• Responder successfully protests an award.	
Performance Measures	• Time to complete process = _____months;_____weeks variable • Accuracy of information =__100 % • Accessibility of information for creating solicitation =_____ • Consistency of decisions and disposition =100_____ • Error rate = __% or less	

3.3.3.2.2 As-Is Assessment

The overall rating for the Award Contract business process is '2'. DMAS goes through a careful determination process before awarding a contract which requires in house experts to manually examine each RFP response. However, the announcement is published on public portal.

Other items noted in the As-Is assessment were:

- Virginia's procurement regulations require that we negotiate contract before we make the award. This should be occurring before a decision has been made as required by eVA.
- DMAS's Contractor data store excludes provider network for contract records retained in the Division of Budget and Contract Management at the agency.

3.3.3.2.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Award Contract business process:

- Identify manual steps in the process and automate them wherever possible.
- Create a central Contractor data store that contains past RFP, RFI, and RFQ materials that can be used as a reference for future solicitations.

- Identify and implement meaningful ways to include the provider network into the central Contractor data store.
- Automate the business rules to the extent possible.
- Collaborate with other intrastate and entities to adopt national standards and to develop and share reusable business services.
- Establish meaningful metrics to track the accuracy, timeliness, and effectiveness of the Award Contract business process.

3.3.3.2.4 Scorecard

The following scorecard was compiled for the Award Contract business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contract Management Award Contract	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		

Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.3.3.3 Manage Contract

The following sections provide the business process model, a summary of the As-Is and To-Be assessments and the Business Architecture scorecard for the Manage Contract business process.

3.3.3.3.1 Business Process Model

The Manage Contract business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contract Management		
Manage Contract		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Contract*** business process receives the contract award information, implements contract-monitoring procedures, updates contract if needed, and continues to monitor the terms of the contract throughout its duration. At DMAS the Contract Administrator makes the determination that a contract modification is needed.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive negotiated contract information from ***Award Contract*** business process. • Periodic timetable (e.g., yearly) is due for contract review. • External event (e.g., policy, budget modification) necessitates contract amendment. • Receive contract modifications (e.g.,	

CO Contract Management		
Manage Contract		
Item	**Details**	**DMAS Differences/Comments**
	create, updated, or delete). • Receive terminate contract information from ***Close Out Contract*** business process.	
Result	• Modified negotiated contract. • If applicable, alert sent to ***Manage Contractor Information*** business process with modification information. • Alert to send notification to contractor of modification to contract. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive contract award information from the ***Award Contract*** business process or contract update information from the ***Manage Contractor Communication*** business process. 2. Implement contract or modifications to contract. 3. If applicable, update contract with amendments. 4. If applicable, send alert to Manage Contractor Information business process with modified information. The contract administrator identifies the need for contract modification. 5. This is a shared responsibility between the contract administrator and the Office of Budget and Contracts Management. 6. END: Send alert to Manage Contractor Communication business process to notify contractor of modifications.	

CO Contract Management		
Manage Contract		
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Contractor Information Data Store	
Predecessor	***Award Contract*** *Close out Contract Not applicable*	
Successor	***Manage Contractor Communication*** *Manage Contractor Information* **Manage Contractor Performance**	
Constraints	Business rules and/or policies may differ by state.	
Failures	• The State Medicaid Agency (SMA) loses funding. • Responder successfully protests an award. Not applicable, out of the award stage, protests happen prior to award. • The SMA fails to negotiate terms of contract or modification. • Information does not comply with syntax criteria. • Not all required information provided. • Information provided not authenticated.	
Performance Measures	• Time to complete process = _____months; _____ weeks variable • Accuracy of information =__100% • Accessibility of information for creating solicitation =_____ • Consistency of decisions and disposition =__	

CO Contract Management		
Manage Contract		
Item	**Details**	**DMAS Differences/Comments**
	• Error rate = **0** % or less	

3.3.3.3.2 As-Is Assessment

The overall rating for the Manage Contract business process is '2'. The process has well defined performance standards such as Service Level Agreements in place.

One other item noted in the As-Is assessment was:

- At DMAS the Contract Administrator makes the determination that a contract modification is needed.

3.3.3.3.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Manage Contract business process:

- Identify manual steps in the process and automate them wherever possible.
- Create a central Contractor data store that service level agreements and other contract materials that can be used as a reference for future solicitations.
- Automate the business rules to the extent possible.
- Collaborate with other intrastate and entities to adopt national standards and to develop and share reusable business services.
- Establish meaningful metrics to track the accuracy, timeliness, and effectiveness of the Manage Contract business process.

3.3.3.3.4 Scorecard

The following scorecard was compiled for the Manage Contract business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contract Management Manage Contract	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3

Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.3.3.4 Close Out Contract

The following sections provide the business process model, a summary of the As-Is and To-Be assessments and the Business Architecture scorecard for the Close Out Contract business process.

3.3.3.4.1 Business Process Model

The Close Out Contract business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

CO Contract Management		
Close Out Contract		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Close Out Contract*** business process begins with an expired contract or an order to terminate a contract. The business process ensures the obligations of the current contract are complete and the turnover to the new contractor proceeds according to contractual obligations.	All contractors are 'enrolled' on the MMIS provider database as class type 107 to allow payment processing. The 'eligibility end date' is the contract end date.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive alert from ***Determine Adverse Action Incident*** business process to cease activities with contractor. Environment-based Trigger Events to include but not limited to: • Contract reaches the end of its effective period.	60 day notice is sent and plan established for closing contract
Result	• The contract closes. • Alert sent to notify contractor of termination of contract. • Tracking information as needed for measuring performance and business activity monitoring.	In addition to Contract Administrator notifying contractor of termination of contract, eVA notifies contractor through PO process that no more renewals are available
Business	1. **START:** Receive expired contract or instruction to terminate a contract.	'Instructions to terminate' are usually initiated 60 days prior to

CO Contract Management		
Close Out Contract		
Item	**Details**	**DMAS Differences/Comments**
Process Steps	2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 3. If applicable, request additional information. 4. Validate information provided is authentic. 5. Identify all requirements for termination of contract. 6. Monitor closure activities. 7. Officially terminate contract. 8. **END:** Send alert to notify contractor of termination of contract.	end of contract (but exact period is established by contract).
Shared Data	Contractor data store including contract information	Spreadsheet with information about all contracts
Predecessor	***Award Contract*** *Determine Adverse Action Incident*	
Successor	***Manage Contractor Communication*** *Manage Contractor Information*	
Constraints	Each state may have its own requirements	

CO Contract Management		
Close Out Contract		
Item	**Details**	**DMAS Differences/Comments**
	for contract termination.	
Failures	• The State Medicaid Agency (SMA) receives incomplete termination instructions. • Contractor data store contains invalid information.	
Performance Measures	• Time to complete process =____months;__ • Accuracy of information =____% • Accessibility of information for terminating contract =_____ • Consistency of decisions and disposition =_____ • Error rate = __% or less	• Time to complete is usually 60 days, but determined by contract • Accuracy = 100% • Information accessible at all times • Consistency = 100% • Error rate = 0%

3.3.3.4.2 As-Is Assessment

The overall rating for the Close Out Contract business process is '2'. The process is a combination of manual intervention and electronic notification of when the contract is ready to expire.

Other items noted in the As-Is assessment were:

- All contractors are 'enrolled' on the MMIS provider database as class type 107 to allow payment processing. The 'eligibility end date' is the contract end date. 60 day notice is sent and plan established for closing contract.
- In addition to Contract Administrator notifying contractor of termination of contract, eVA notifies contractor through PO process that no more renewals are available 'Instructions to terminate' are usually initiated 60 days prior to end of contract (but exact period is established by contract).

3.3.3.4.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Close Out Contract business process:

- Identify manual steps in the process and automate them wherever possible.
- Create a central Contractor data store that contains past RFP, RFI, and RFQ materials that can be used as a reference for future solicitations.
- Automate the business rules to the extent possible.
- Collaborate with other intrastate and entities to adopt national standards and to develop and share reusable business services.
- Establish meaningful metrics to track the accuracy, timeliness, and effectiveness of the Close Out Contract business process.

3.3.3.4.4 Scorecard

The following scorecard was compiled for the Close Out Contract business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
CO - Contract Management Close Out Contract	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		

Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.4 ELIGIBILITY AND ENROLLMENT MANAGEMENT

OVERVIEW

The Eligibility and Enrollment Management business area is a collection of business processes involved in the activity for determination of eligibility and enrollment for new applicants, redetermination of existing members, enrolling new providers, and revalidation of existing providers. The Provider Enrollment business category and related business processes focus on patient safety and fraud prevention through functions such as determining screening level (i.e., limited, moderate or high) for provider verifications. These processes share a common set of provider-related data for determination of eligibility, enrollment, and inquiry to provide services. The Eligibility and Enrollment Management business area is responsible for the eligibility and enrollment information of the member data store as well as the provider data store.

The Eligibility and Enrollment Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.4-1.

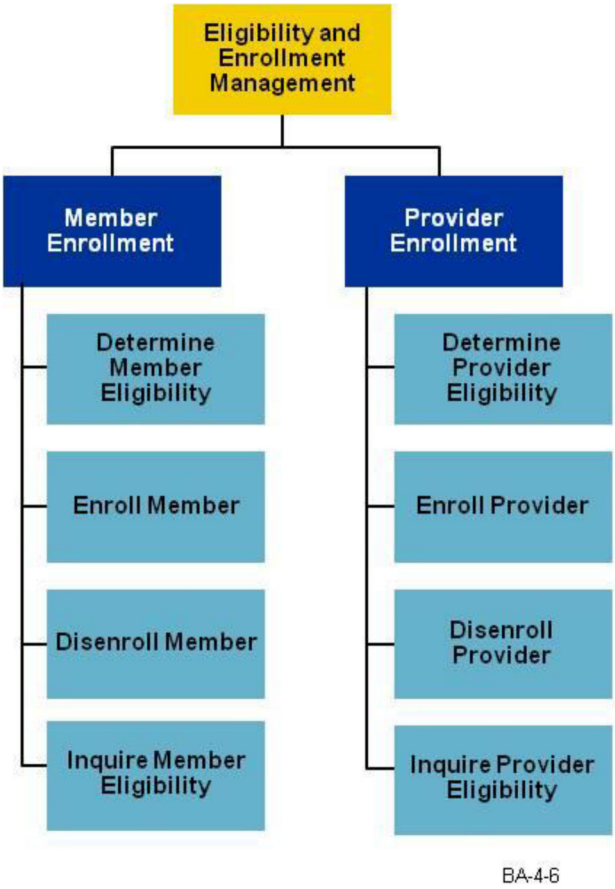

Eligibility and Enrollment Management
Member Enrollment
Provider Enrollment
Determine Member Eligibility
Enroll Member
Disenroll Member
Inquire Member Eligibility
Determine Provider Eligibility
Enroll Provider
Disenroll Provider
Inquire Provider Eligibility
BA-4-6

Figure 3.4-1

BUSINESS ARCHITECTURE PROFILE

The Eligibility and Enrollment Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Eligibility & Enrollment Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Determine Member Eligibility		As-Is	To-Be		
Enroll Member		As-Is	To-Be		
Disenroll Member		As-Is	To-Be		
Inquire Member Eligibility			As-Is / To-Be		
Determine Provider Eligibility		As-Is	To-Be		
Enroll Provider		As-Is	To-Be		
Disenroll Provider		As-Is	To-Be		
Inquire Provider Eligibility		As-Is	To-Be		

3.4.1 Member Enrollment

As shown in Figure 3.4-1, the Member Enrollment business category is made up of four business processes:

- Determine Member Eligibility
- Enroll Member
- Disenroll Member
- Inquire Member Eligibility.

Details regarding the assessment of each Member Enrollment business process follow.

3.4.1.1 Determine Member Eligibility

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Determine Member Eligibility business process.

3.4.1.1.1 Business Process Model

The Determine Member Eligibility business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

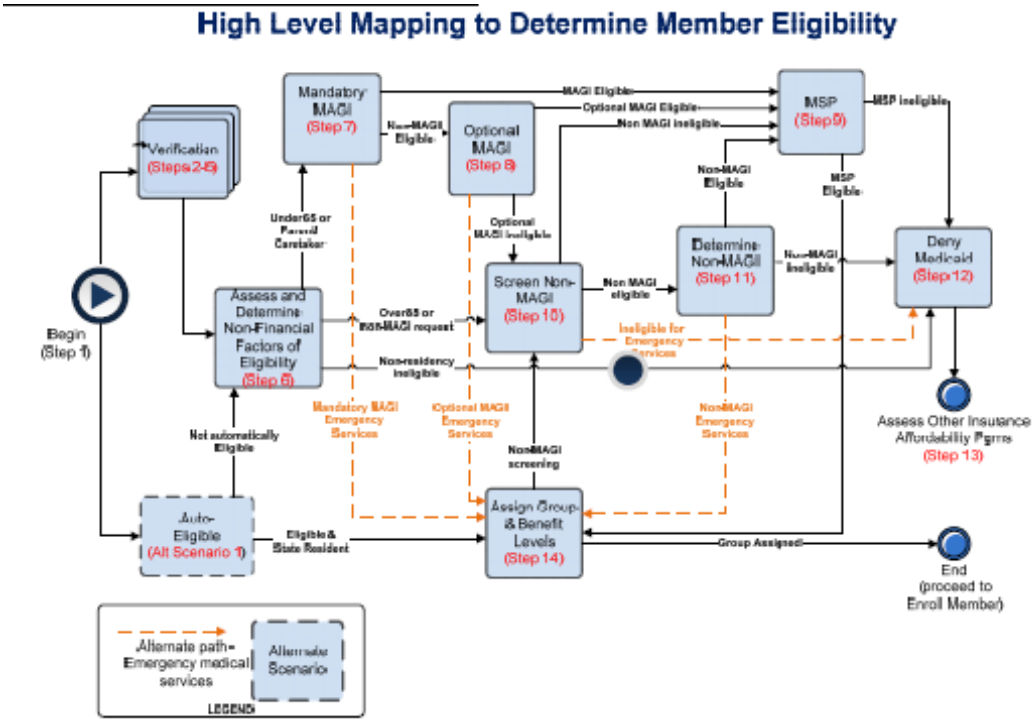
EE Member Enrollment		
Determine Member Eligibility		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Determine Member Eligibility*** business process is responsible for the operational aspects of determining if an applicant is eligible for Medicaid or potentially eligible for other insurance affordability programs (e.g., Advance Premium Tax Credits through the Health Insurance Marketplace (HIX) commonly referred to as the Marketplace. Children's Health Insurance Program [CHIP], and/or Basic Health Program [BHP]). An applicant submits an application or a member updates account information via online, in person, over the phone, by mail, or by other commonly available electronic means. The business process checks for status (e.g., new, resubmission, redetermination, duplicate, or referral from the Health Insurance Marketplace or other agencies administering insurance affordability programs) and verifies applicant information in accordance with the policies established. The business process determines eligibility based on modified adjusted gross income (MAGI) or on a basis other than MAGI methods including group/category (e.g., parents/caretaker relatives, pregnant women, children under 19 year of age). The business process also assigns a Medicaid ID, associates the benefit packages, and produces notifications for coordinated communications. When required, the State Medicaid Agency (SMA) submits applicant or member eligibility information and/or eligibility determination to other agencies administering insurance affordability programs and CMS information systems. This business process could be a Shared Eligibility Service between the Medicaid Agency, the Health Insurance Marketplace, and other State-based insurance affordability programs such as CHIP or BHP. **NOTE: Applications and Accounts:** An	Basic Health Program is not applicable to Virginia. DMAS calls CHIP "FAMIS" DSS processes applications that come into their offices for Medicaid, Disability, ABD (aged, blind, disabled) or LTC application or person is seeking coverage through multiple programs. The Cover Virginia call center site is processing all applications using the MAGI rules. To include, applications transferred from the marketplace that have been assessed as being possibly eligible for Medicaid. MAGI supports the new rules for family and children's groups, MAGI that come from Common Help (DSS portal) and Federally Facilitated Marketplace applications.

EE Member Enrollment		
Determine Member Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	individual seeking eligibility for enrollment in an insurance affordability program completes and submits an application on-line, in person, over the phone, by mail, or paper application for verification and eligibility determination. Accepted application data is managed in an "electronic account" (as defined in 42 CFR 435.4) by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes.	
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receipt of referral of Medicaid applicant from the Health Insurance Marketplace, CHIP or BHP. • Receipt of individuals based on Auto-Eligibility, such as Deemed Newborns, SSI/1634, Title IV-E Foster Care, Adoptions and Guardianship. Environment-based Trigger Events to include but not limited to: • Receive application via online, in person, over the phone, by mail, or other commonly available electronic means. • Periodic timetable (e.g., annual) for existing member who is due for redetermination of eligibility. Applicant or authorized representative responds to	BHP does not apply to VA SSI/1634 does not apply to VA Individuals may request services and assessment of medical needs for additional benefits such as long-term care, early intervention, and waiver services. Individuals may place an application for enrollment in the Health Insurance Premium Payment (HIPP) program. Can also FAX in an application

EE Member Enrollment		
Determine Member Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	renewal form by providing information via online, in person, over the phone, by mail, or other commonly available electronic means. • Receive modification to application from applicant or authorized representative or change report from member or authorized representative or from other data sources.	
Result	• Eligibility is determined as approved, continued, denied, terminated, suspended, or pended for additional information and review. • Tracking information as needed for measuring performance and business activity monitoring.	We do not suspend (leave someone open but inactive). We do pend for missing information.

Business Process Steps

Full Eligibility Determination or Renewal



1. **START:**

   a. Receive completed application from applicant via online or by other commonly available electronic means, in person, over the phone, or by mail, or receive initial assessment from another insurance affordability program; or

   NOTE: The use of the internet website (online portal) will include not only field-level edits but will also perform data verification, as appropriate, throughout the application preparation and update process as well as determine if the account already exists (in the Health Insurance Marketplace, Medicaid and/or CHIP) and the status of application/account.

   b. Initiate renewal process when member's response to renewal notice is received or when changes to existing member account is updated with new information from other data source(s); or

   c. Receive information about an auto-eligible. Go to Alternate Scenario 1.

Verifications

General Note:

DMAS determines and assigns eligibility for a single group, and the member is assigned to the group that provides the most benefits ("cast the widest net").

As a result, our processing flow differs in that the determination process is stopped once a member is determined to qualify for the best possible eligibility group. However, the objectives of the DMAS process are consistent with this flow, other than potentially assigning multiple groups.

NOTE: Conduct steps 2, 3, and 4 simultaneously or in any order in accordance with State's established verification plan (42 CFR 435.945(j)). Financial Information will be verified if financial assistance is requested and the information is provided. Verify asset information if applicant has requested to be evaluated for Medicaid eligibility based on a non-MAGI group that requires an asset test.

Verify Non-Financial Requirements

2. Verify the following non-financial requirements for eligibility determination. CMS expects the State to use Federal or local electronic data sources as available. The State may also rely on self-attestation for all eligibility criteria other than citizenship and satisfactory immigration status, as described in Section H of the preamble of the Medicaid Final Eligibility Rule. Resolve discrepancies by identifying non-financial factors that do not meet verification based on data matches or self-attestation and request additional information as necessary.
    a. Verify State residency.
    b. Verify the SSN.
    c. Verify citizenship or satisfactory immigration status.
    d. If applicable, verify whether individual is an American Indian/Alaska Native, in accordance with established procedure. **Note**: American Indian/Alaska Native status is not a condition of eligibility for Medicaid.
    e. If applicable, verify individual incarceration status. **Note:** Incarceration status is not a condition of eligibility for Medicaid.
    f. Pregnancy. **Note**: The Agency must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation.
    g. Age, date of birth and household size. **Note**: The Agency may accept self-attestation of date of birth and the individuals that comprise an individual's household or may verify through other reasonable verification procedures.
    h. Other non-financial factors (e.g., full-time student status, categorical eligibility as a parent or other caretaker relative as defined in 42 CFR 435.4).

Step 2.a: We don't verify state residency unless we have reason to believe the applicant is not a resident of VA.

Verify Other Health Coverage

3. Verify enrollment in other health coverage, including Medicare, other public programs, as well as private coverage. **Note:** Enrollment in private health coverage is not a barrier to Medicaid eligibility except as an optional targeted low-income child or as a woman needing treatment for breast or cervical cancer. Medicare recipients are exempted from certain eligibility groups, while Medicare coverage is required for certain other eligibility groups.

Verify Financial Information

4. Verify financial information (42 CFR 435.948) provided by the applicant or member, including:
    a. Information related to wages, net earnings from self-employment, and unearned income and resources with the appropriate source (e.g., State Wage Information Collection Agency (SWICA), IRS, Social Security Administration, State unemployment compensation, and State-administered supplementary payment programs)
    b. Information related to the eligibility or enrollment from the Supplemental

Nutrition Assistance Program, the State program funded under part A of Title IV of the Act, and other insurance affordability programs.

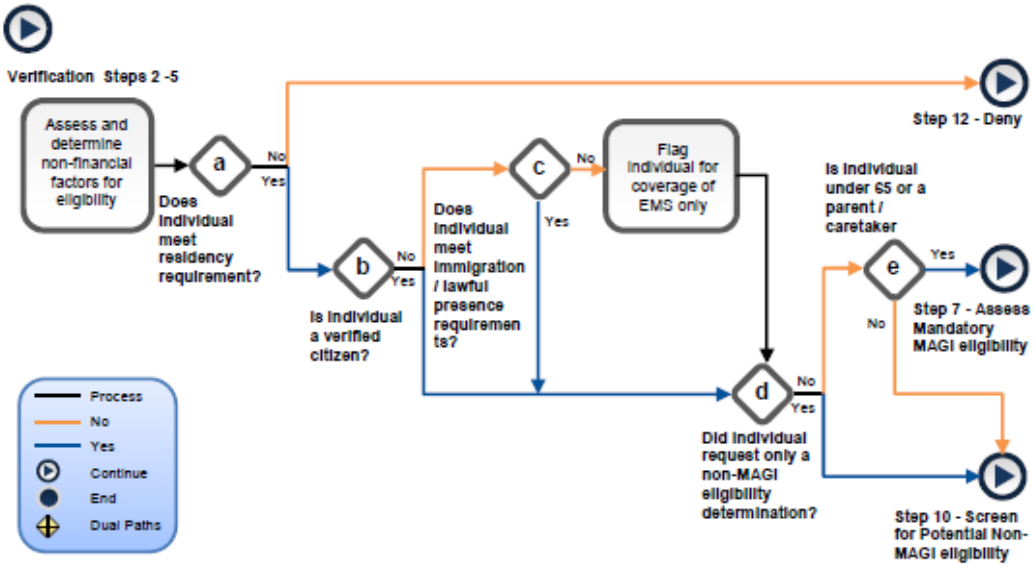
Verify Asset Information

5. Verify asset information if applicant has requested to be evaluated for Medicaid eligibility based on a non-MAGI group that requires an asset test.

Determine Individual Medicaid Eligibility

Assess and Determine Individual Non-Financial Factors of Eligibility

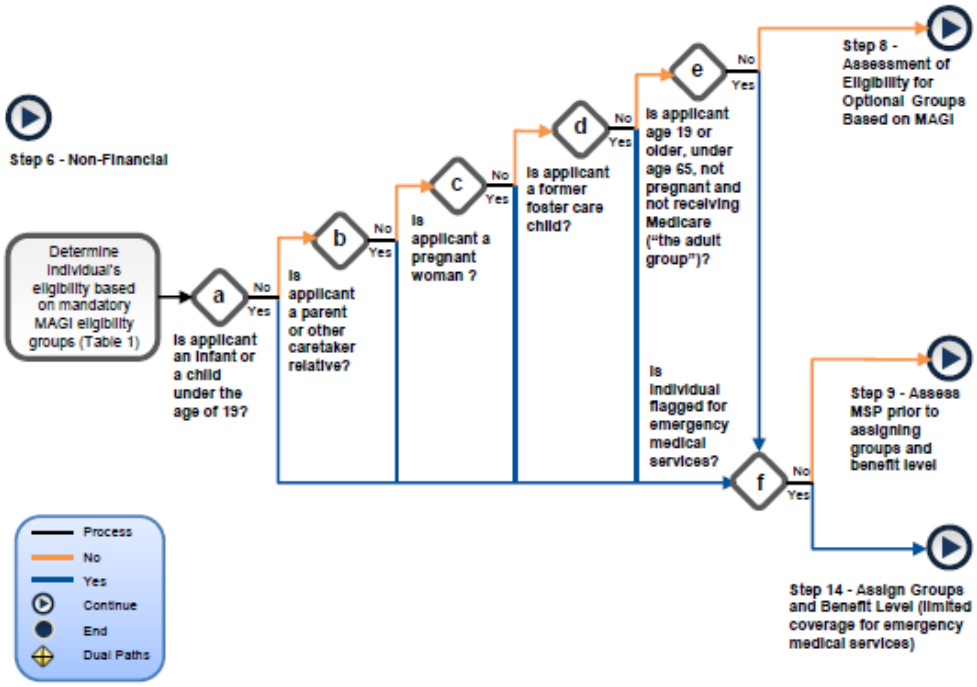
Step 6 - Assess Non-Financial Factors



6. Use results from verification processes and other application data to assess and determine whether the individual meets the non-financial factors for eligibility:
   a. If individual meets residency requirement, go to Step 6b. If not, go to Step 12 to deny Medicaid.
   b. If individual is a verified citizen, go to Step 6d. If not, continue to Step 6c.
   c. If individual meets satisfactory immigration status requirements, go to Step 6d. If not, flag individual for coverage of emergency medical services and proceed to Step 6d.
   d. If individual is requesting only a non-MAGI eligibility determination, go to Step 10 to screen for non-MAGI. If not, go to Step 6e.
   e. If individual is under age 65 or a parent / caretaker, go to Step 7 to assess and determine eligibility for mandatory MAGI. If not, go to Step 10 to screen for potential non-MAGI eligibility.

Assess and Determine Eligibility for Mandatory MAGI Eligibility Groups

Step 7 - Mandatory MAGI



7. Determine individual's eligibility based on mandatory MAGI eligibility groups. **Note:** See Mandatory MAGI Groups Table 1.

   a. Assess whether the applicant/member is eligible as an infant or a child under the age of 19. (42 CFR 435.118). If yes, go to Step 7f. If not, go to Step 7b.

   b. Assess whether the applicant/member is eligible as a parent or other caretaker relative (42 CFR 435.110). If yes, go to Step 7f. If not, go to Step 7c.

   c. Assess whether the applicant/member is eligible as a pregnant woman (42 CFR 435.116). If yes, go to Step 7f. If not, go to Step 7d.

   d. Assess whether the applicant/member is eligible as a former foster care child (no income test) (42 CFR 435.150). If yes, go to Step 7f. If not, go to Step 7e.

   e. Assess whether individual is age 19 or older and under age 65, not pregnant, is not receiving Medicare (42 CFR 435.119) and is therefore eligible as part of "the adult group". If yes, go to 7f , if not, go to Step 8 to assess individual for optional MAGI groups.

   f. If individual is flagged for emergency medical services only, go to Step 14 to assign groups and benefit level (limited coverage for emergency services). If not, go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility prior to assigning groups and benefit level *(however, if the individual is determined eligible as part of the "adult group" they will pass through Step 9 to Step 14).*

Step 7: 7.E we don't cover the expanded Medicaid group.

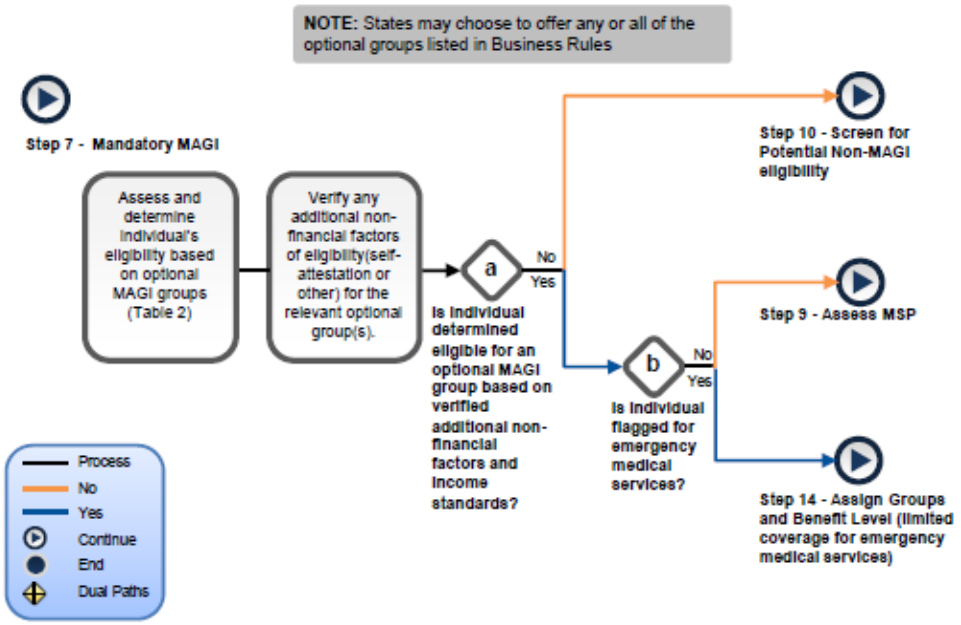
(Step "f" is an example of where our process differs; once determined eligible for MAGI, process

Table 1:	Mandatory MAGI Groups
42 CFR 435.118	Less Than 19
42 CFR 435.110	Parent / Caretaker Relative
42 CFR 435.116	Pregnant
42 CFR 435.150	Former Foster Care Child
42 CFR 435.119	Adult Group

would not continue to assess MSP.)

Assess and Determine Eligibility for Optional Eligibility Groups Based on MAGI

Step 8 - Optional MAGI



8. Assess and determine individual's eligibility based on optional MAGI groups. States may choose to offer any or all of the optional groups listed in Table 2. Verify (by self-attestation or otherwise) any additional non-financial factors of eligibility for the relevant optional group(s).

    a. If an individual meets non-financial factors and income standards for an optional MAGI group, go to Step 8b. If not, go to Step 10 to screen for potential non-MAGI eligibility.

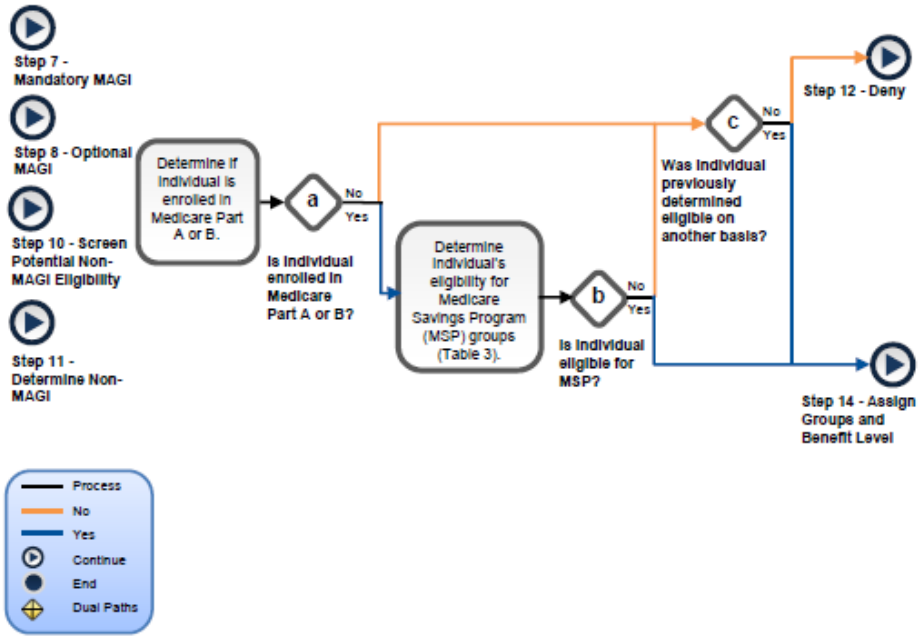
    b. If individual is flagged for emergency medical services only, go to Step 14 to assign groups and benefit level (limited coverage for emergency services). If not, go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility prior to assigning groups and benefit level.

Table 2:	Optional MAGI Groups
42 CFR 435.220	Optional Parent / Caretaker Relative
42 CFR 435.222	Optional Reasonable Classifications of Children <21
42 CFR 435.227	Optional State Adoption Assistance Children <21
42 CFR 435.229	Optional Targeted Low-Income Children <19
42 CFR 435.226	Optional Chafee Independent Foster Care Adolescents <21
42 CFR 435.218	Optional Individuals Above 133% FPL <65
Social Security Act Sec. 1902(a)(10)(F)	Optional COBRA Continuation Group
42 CFR 435.215	Optional Tuberculosis Group (TB)
42 CFR 435.214	Optional Family Planning Group

See notes for Table 2 at the end of the model.

Assess and Determine Medicare Savings Program (MSP) eligibility

Step 9 - Assess and Determine MSP



9. Prior to approving or denying Medicaid eligibility, assess and determine if individual is eligible for a Medicare Savings Program. **Note:** See Medicare Savings Program Groups Table 3.
    a. Determine if individual is enrolled in Medicare Part A or B. If enrolled in Medicare Part A or B, go to Step 9b. If not, go to Step 9c.
    b. Determine if individual is eligible for a Medicare Savings Program Group. If

Step 9, 10, 11: Once a person has been found eligible we stop

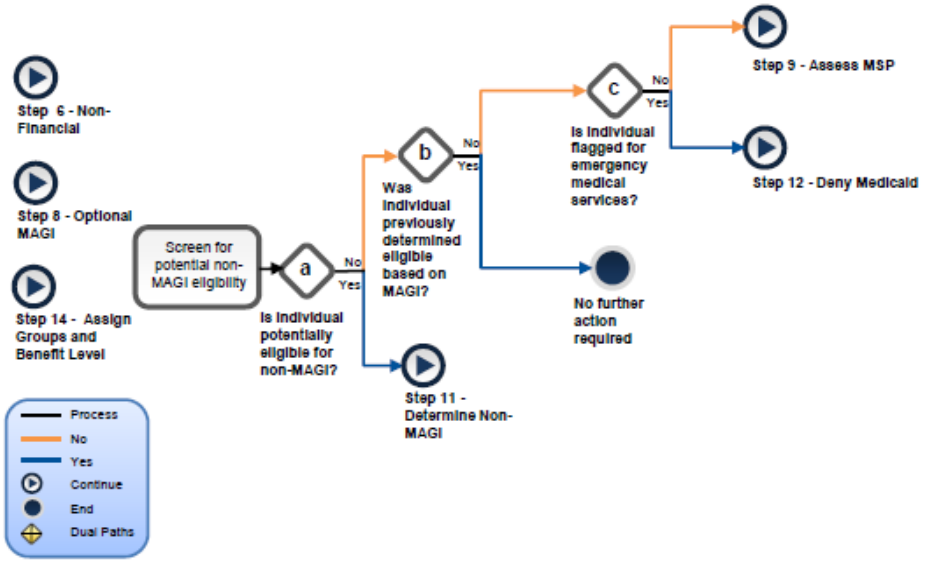
the individual is eligible based on MSP criteria, go to Step 14 to assign groups and benefit level. If not, go Step 9c.

c. If individual was previously determined eligible on another basis, go to Step 14 to assign groups and benefit level. If not, go to Step 12 to deny Medicaid.

Table 3:	Medicare Savings Program Groups
Social Security Act, Sec. 1902(a)(10)(E)(i),1905(p)	Qualified Medicare Beneficiary (QMB)
Social Security Act, Sec. 1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii)	Specified Low Income Medicare Beneficiary (SLMB)
Social Security Act, Sec. 1902(a)(10)(E)(iv), 1905(p)(3)(A)(ii)	Qualifying Individuals (QI)
Social Security Act, Sec. 1902(a)(10)(E)(ii), 1905(s), 1905(p)(3)(A)(i)	Qualified Disabled and Working Individuals (QDWI)

Screen for Potential non-MAGI eligibility

Step 10 - Screen Potential Non-MAGI Eligibility



10. Screen individual for potential non-MAGI eligibility based on application information:

a. If individual has requested a non-MAGI eligibility determination or application data indicates potential eligibility for non-MAGI (e.g. indicators of disability, blindness, aged, or a need for long term care services), go to

at that point. The only time determination would go all the way to the end and on to MSP screening is when the member is ineligible for any other covered group and has Medicare.

Step 11 to determine eligibility on basis other than MAGI. If not, go to Step 10b.

b. If individual was previously determined eligible based on MAGI, no further action required. If not, go to 10c.

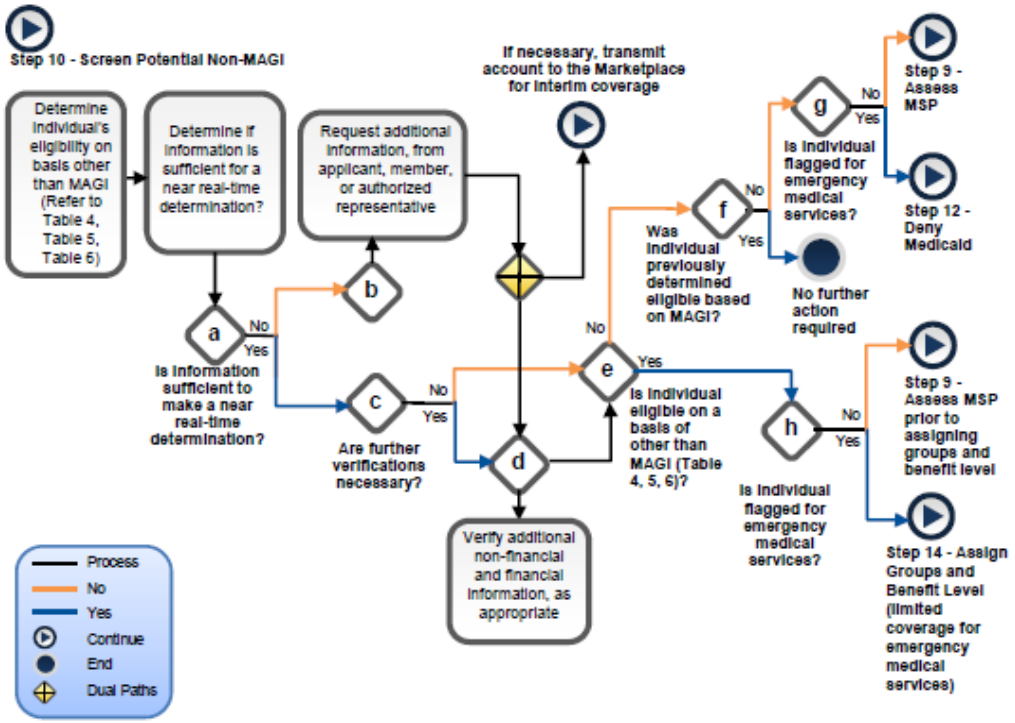
c. If individual is flagged for emergency medical services only, go to Step 12 to deny Medicaid. If not go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility

NOTE: Although the individual was flagged for emergency medical services, the individual has failed all other income tests and the screening for potential non-MAGI and should be denied coverage for emergency medical services.

Step 10.c: The way the chart depicts step 10.c going to step 12 is confusing – Is individual flagged for emergency medical services? If Yes, deny Medicaid, does not make sense for us11b: Interim coverage is an outcome once the final determination has been made. We do not transmit to the Marketplace as an interim step.

Determine Eligibility on Basis Other than MAGI

Step 11 - Determine Eligibility on Basis Other than MAGI



11. Determine individual's eligibility on basis other than MAGI. **Note:** See Optional Non-MAGI Groups Table 4, Age, Blind, Disabled (ABD) Optional Coverage Groups Table 5 and Medically Needy Groups Table 6.

    a. Determine if information is sufficient for a near real-time determination. If yes, go to Step 11c. If not, go to Step 11b.

    b. Request additional information from applicant, member, or authorized representative (e.g., electronic verifications for former foster care children). Proceed to Step 11d; and if necessary, transmit account (*Manage Member Information*) to the Health Insurance Marketplace for interim coverage.

    c. Determine if further verifications are necessary. If yes, go to Step 11d. If not, go to Step 11e.

d. Verify additional non-financial and financial information (income and assets), as appropriate, according to methodologies for applicants or members who may be eligible on basis other than MAGI. Go to Step 11e.

e. If individual is eligible on a basis of other than MAGI, go to Step 11h. If not, go to Step 11f.

f. If individual was previously determined eligible based on MAGI, no further action is required. If not, go to 11g.

g. If individual is flagged for emergency medical services only, go to Step 12 to deny Medicaid. If not, go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility.

NOTE: Although the individual requested coverage for emergency services, the individual has failed all income tests (MAGI and non-MAGI) and should be denied Medicaid.

h. If individual is flagged for emergency medical services only, go to Step 14 to assign groups and benefit level (limited coverage for emergency services). If not, go to Step 9 to assess and determine Medicare Savings Program (MSP) eligibility prior to assigning groups and benefit level.

Table 4:	Non MAGI Optional Groups
42 CFR 435.213	Optional Individuals with Breast / Cervical Cancer 21-64 (No Income Test)
42 CFR 435.222	Optional Reasonable Classifications of Children <21 (No Income Test)
42 CFR 435.227	Optional State Adoption Assistance Children <21 (No Income Test)
42 CFR 435.226	Optional Chafee Independent Foster Care Adolescents <21 (No Income Test)
See Table 5	Aged, Blind or Disabled
42 CFR 435.236	Special Income – Level Group
42 CFR 435.217	Individual eligible for Home and Community based services using institutional rules
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XXII), 1915(i)	Individual eligible for Home and Community based services (150% FPL)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XXII), 1915(i)	Individual eligible for Home and Community based services Special Income Level

See notes for Table 4 at the end of the model.

See notes for Table 5 at the

Table 5:	ABD Groups
42 CFR 435.210	Individuals Eligible for but not Receiving Cash
42 CFR 435.211	Individuals Eligible for Cash except for Institutionalization
42 CFR 435.212	Individuals in HMOs Guaranteed Eligibility
Social Security Act, Sec. 1934	Individuals participating in a PACE program under Institutional Rules
Social Security Act, Sec. 1902(a)(10)(A)(ii)(VII), 1905(o)	Individuals Receiving Hospice Care
42 CFR 435.232	Optional State Supplemental Recipients - 1634 States, and SSI Criteria States with 1616 Agreements
42 CFR 435.234	Optional State Supplemental Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements
Social Security Act, Sec. 1902(e)(3)	Qualified Disabled Children under 19 (TEFRA Kids)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(X), 1902(m)(1)	Poverty Level Aged or Disabled
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XIII)	Work Incentives Eligibility Group (BBA)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XV)	Ticket to Work Basic Group (TWWIIA)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XVI)	Ticket to Work Medical Improvements Group (TWWIIA MI)
Social Security Act, Sec. 1902(a)(10)(A)(ii)(XIX)	Family Opportunity Act for Children with Disabilities (FOA)

end of the model.

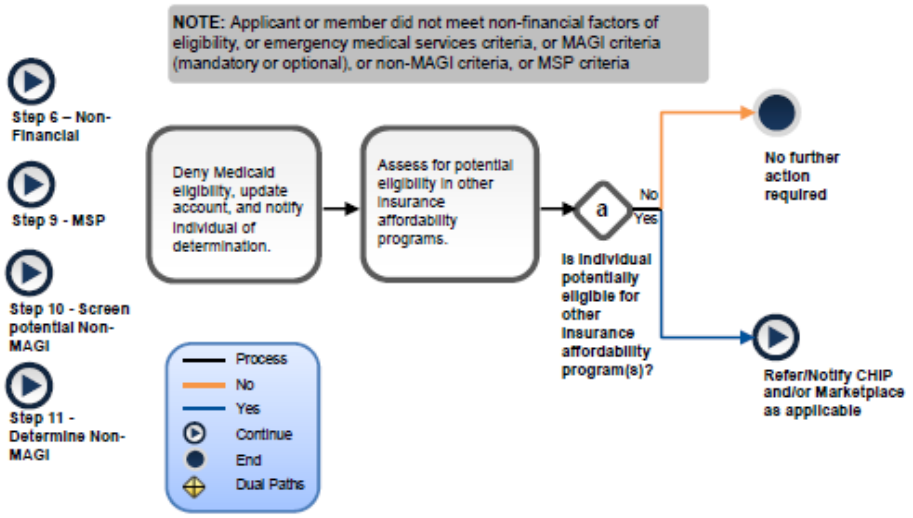
Table 6:	Medically Needy Groups
42 CFR 435.301	Less than 18
42 CFR 435.308	18-20
42 CFR 435.301	Pregnant Women
42 CFR 435.310	Parent / Caretaker Relative
42 CFR 435.320, 435.330	Aged
42 CFR 435.322, 435.330, 435.340	Blind
42 CFR 435.324, 435.330, 435.340	Disabled

See notes for Table 6 at the end of the model.

Deny Medicaid and Assess for Other Insurance Affordability Programs

Step 12 &13 - Deny Medicaid & Assess for Other Insurance Affordability

Program

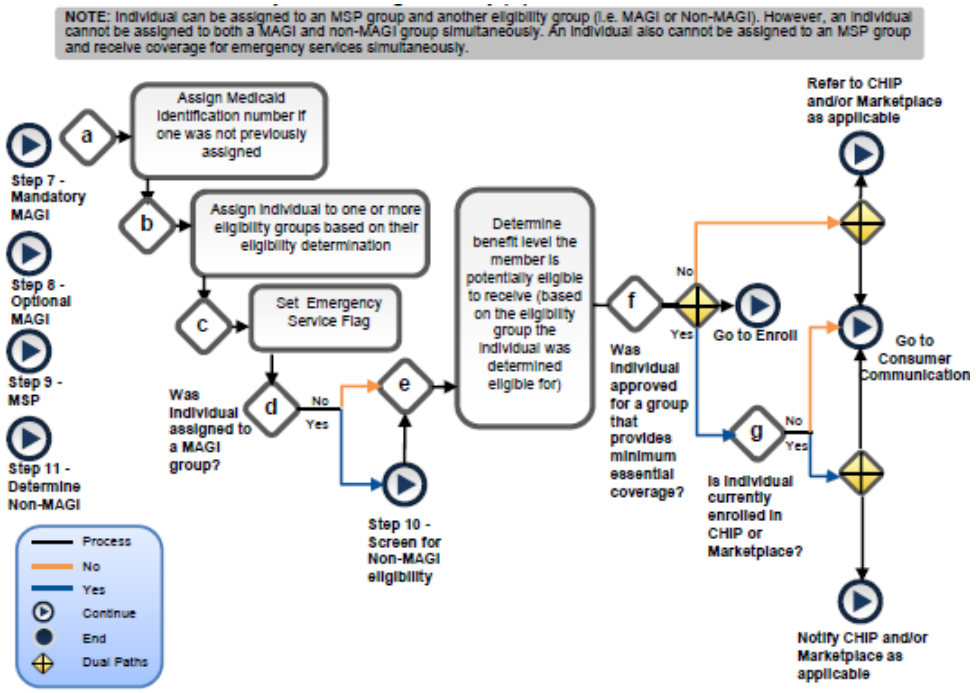


12. Deny Medicaid eligibility, update account *(ME-01 Manage Member Information*) and notify individual (*Manage Applicant and Member Communication*) of determination.
13. Assess individual for other Insurance Affordability Programs
    a. Assess for potential eligibility in other insurance affordability programs. If individual is potentially eligible for other insurance affordability program refer/notify CHIP and/or Health Insurance Marketplace as applicable. *(Manage Member Information).* If not, no further action required.

Assign Groups and Benefit Levels

Step 14 - Assign Group(s) and Benefit Level

Step: 12 & 13: When we complete the eligibility determination for Medicaid and FAMIS (CHIP) and find the person ineligible, we may refer them to the Marketplace, but we do not do a true assessment. The Marketplace is the default if they don't qualify for



14. Assign group and benefit levels as appropriate.

    a. Assign Medicaid identification number to member if one was not previously assigned.

    b. Assign individual to one or more eligibility groups based on their eligibility determination: MAGI group, Non-MAGI group, and/or Medicare Savings Program (MSP) group.

    NOTE: Individual can be assigned to a Medicare Savings Program (MSP) group and another eligibility group (i.e. MAGI or non-MAGI). However, an individual cannot be assigned to both a MAGI and non-MAGI group simultaneously. An individual also cannot be assigned to an MSP group and receive coverage for emergency services simultaneously.

    c. Flag individuals determined eligible for emergency medical services.

    NOTE: Individuals eligible for coverage of emergency medical services will receive a limited benefit plan.

    d. If the individual was determined eligible for MAGI go to Step 10 to screen individual for non-MAGI eligibility and proceed to 14e. If not, the individual was determined eligible based on non-MAGI, continue to 14e.

    e. Determine the health benefit level the member is eligible to receive and then proceed to 14f.

    f. Go to **Enroll member**, to enroll individual in the appropriate eligibility group(s); and determine if individual was approved for a group that provides minimum essential coverage. If yes, individual is approved for a group that provides minimum essential coverage, go to 14g. If no, refer to CHIP and/or Health Insurance Marketplace as applicable (Manage Member Information); and notify individual (Manage Applicant and Member Communication) of determination.

Medicaid or CHIP.

FAMIS (CHIP) eligibility determination is performed as part of the Medicaid eligibility determination process; it is not referred to a different entity.

Step 14: As noted above, DMAS enrolls a person in only one Medicaid coverage group. A member is assigned to the coverage group that provides the greatest coverage for the person. That coverage group may provide the

g. If individual is currently enrolled in CHIP or the Health Insurance Marketplace, notify CHIP and/or the Health Insurance Marketplace as applicable of individual's enrollment in Medicaid for potential disenrollment; and notify individual (Manage Applicant and Member Communication) of determination. If not currently enrolled in CHIP or Health Insurance Marketplace, notify individual of determination.

15. **END**

equivalent of multiple benefits. We have very granular aid categories that define the appropriate benefits.

Alternate Scenario 1 – Auto Eligible

1. Determine if applicant or member is automatically categorically eligible without a requirement for financial eligibility (e.g., SSI recipients, IV-E children, deemed newborns). Assess if the individual is a State resident. If so, approve Medicaid eligibility and go to step 14. If not, go to step 6. **Note:** See Mandatory Auto Eligible Groups Table 7.

Table 7:	Auto-Eligible Groups *(Not inclusive of Closed Groups)*
Social Security Act, Sec. 1902(e)(4), 42 CFR 435.117	Deemed Newborns
Social Security Act, Sec. 1902(a)(10)(A)(i)(II), 42 CFR 435.120	SSI in a 1634 State
Social Security Act, Sec. 1902(a)(10)(A)(i)(I), 42 CFR 435.145	Title IV-E Foster Care, Adoption and Guardianship
Social Security Act, Sec. 1902(a)(10)(A)(i)(II), 42 CFR 435.120	Individual Receiving SSI
Social Security Act, Sec. 1902(a)(10)(A)(i)(II),1902(f), 42 CFR 435.121	Aged, Blind, and Disabled in 209(b) States
Social Security Act, Sec. 1619(b), 1902(10)(A)(i)(II), 1905(q)	Working Disabled Individuals
Social Security Act, Sec. 1634(c)	Disabled Adult Children
42 CFR 435.130	Individuals Receiving Mandatory State Supplements
42 CFR 435.135	Individuals who would be eligible for SSI/SSP but for OASDI COLA increases since April, 1977
Social Security Act, Sec. 1634(b), 42 CFR 435.137	Disabled widows and widowers ineligible for SSI due to increase in OASDI

See notes for Table 7 at the end of the model.

Shared Data	Member data store including demographics and enrollment information Plan data store Coordination of Benefits data store	DSS and Central Processing Unit staff use data from other systems (IRS, Social Security, VEC, DMV, Child Support) to verify citizenship and social security number and income,
Predecessor	**Receive Inbound Transaction** ***Manage Applicant and Member Communication***	
Successor	**Send Outbound Transaction** ***Enroll Member*** ***Manage Applicant and Member Communication*** ***Manage Member Information*** ***Manage Performance Measures***	
Constraints	The ***Determine Member Eligibility*** business process must be in accordance with federal	

	rules for standard enrollment application and eligibility determination. The State must use minimum and maximum income standards established by the Agency in the Medicaid State Plan.	
Failures	A member eligibility application may fail at the following steps: • Duplicate or cancelled application. • Applicant or member fails to provide additional information as requested. • Required fields missing or not correct. • Verification with internal or external sources is not authenticated. **Note**: The ***Determine Member Eligibility*** business process does not fail because the applicant is ineligible.	
Performance Measures	Performance measures will be addressed under separate guidance. TBD	Overarching performance measures for local DSS offices and CPU are as follows: • Applications must be processed within 45 calendar days unless a disability determination is required in which case we have 90 days. • Pregnant women applications within 10 days • Breast and cervical cancer applications within 10 days • Renewals for current recipients must be processed every 12 months. • Changes for current recipients

		must be evaluated within 30 days. • The CPU contract between DMAS and Xerox has stricter standards that are enforced by Xerox.

TABLE NOTES:

Table 2

CFR/SSA citation	Cover
435.220	No
435.222	Yes
435.227	Yes
435.229	Yes
435.226	No
435.218	No
1902(a)(10)(f)	No
435.215	No
435.214	Yes

Table 4

CFR/SSA citation	Cover
435.213	Yes
435.222	No
435.227	No
435.226	No
435.236	Yes
435.217	Yes
1902(a)(10)(A)(ii)(XXII), 1915(i)150% fpl	No

1902(a)(10)(A)(ii)(XXII)m 1915(i) Special Income level	No

Table 5

CFR/SSA citation	Cover
435.210	Yes…pg women and caretaker relatives only
435.211	Yes
435.212	No
Section 1934 of the SSA	Yes
1902(a)(10)(A)(ii)(VII), 1905(o)	Yes
435.232	No
435.234	Yes
1902(e)(3)	No
1902(a)(10)(A)(ii)(X), 1902(m)(1)	Yes
1902(a)(10)(A)(ii)(XIII)	No
1902(a)(10)(A)(ii)(XV)	Yes
1902(a)(10)(A)(ii)(XVI)	No
1902(a)(10)(A)(ii)XIX)	No

Table 6

CFR/SSA citation	Cover
435.301	Yes
435.308	Yes

435.301	Yes
435.310	No
435.320,330	Yes
435.322, 330, 340	Yes
435.324, 330, 340	Yes

Table 7

CFR/SSA citation	Cover
1902(e)(4), 435.217	yes
1902(a)10(10)(A)(i)(II), 435.120	No
1902(a)(10)(A)(i)(I), 435.145	Yes
435.120	No
435.121	Income eligible, must meet our more restrictive resource requirements
1619(b)	Income eligible, must meet our more restrictive resource requirements
1634(c)	Income eligible, must meet our more restrictive resource requirements
435.130	Yes
435.135	Must meet our more restrictive resource requirements
435.137	Must meet our more restrictive resource requirements

3.4.1.1.2 As-Is Assessment

The overall rating for the Determine Member Eligibility business process is '2.' DMAS and DSS undertook an Enrollment and Eligibility project that has moved the process to Level 3 in those areas that are supported through VaCMS, which is an enhanced eligibility determination and enrollment system

jointly developed by DSS and DMAS that addresses the MITA Seven Standards and Conditions. While national standards and exchanges are used, the process still has some manual components and the transaction error rate is higher than the Level 3 threshold.

Other items noted in the As-Is assessment were:

- MAGI determination is not currently near real-time
- Overdue Medical Assistance (MA) renewals are reported for follow-up
- MA applications received, disposed and pending are also reported
- DSS produces a variety of statistics in a weekly dashboard that provides useful performance measures.

3.4.1.1.3 To-Be Assessment

DMAS intends to achieve Level 3 and move toward Level 4 for the Determine Member Eligibility business process.

Specific objectives include:

- Migration toward completion of the Enrollment and Eligibility Project
- Increased online verification
- Reduction of manual intervention
- Direct access to data
- Focus of manual efforts on exceptions.

These improvements should result in an increase in member and provider satisfaction, increased electronic communication leading toward the overall enhancement of business capability levels.

3.4.1.1.4 Scorecard

The following scorecard was compiled for the Determine Member Eligibility business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
EE - Member Enrollment Determine Member Eligibility	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		

Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.4.1.2 Enroll Member

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Enroll Member business process.

3.4.1.2.1 Business Process Model

The Enroll Member business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

EE Member Enrollment		
Enroll Member		
Item	**Details**	**DMAS Differences/Comments**
	The ***Enroll Member*** business process receives eligibility information from the	BHP is not applicable.

EE Member Enrollment		
Enroll Member		
Item	**Details**	**DMAS Differences/Comments**
Description	***Determine Member Eligibility*** business process, the Health Insurance Marketplace, or any insurance affordability program (e.g., Children's Health Insurance Program [CHIP] or Basic Health Program [BHP]). It determines additional qualifications for enrollment in health benefits for which the member is eligible, and produces notifications for coordination of communications to the member, provider, and to the insurance affordability programs. The Marketplace, Agency or enrollment brokers may perform some or all of the steps in this business process. **NOTE:** There is a separate business process for Disenroll Member. **NOTE: Applications and Accounts -** An individual seeking eligibility for enrollment in a qualified health plan through the Health Insurance Marketplace, advance premium tax credits, cost-sharing reductions, Medicaid, CHIP or BHP completes and submits an on-line, telephone, in-person, or paper application for verification and eligibility determination. The Health Insurance Marketplace or insurance affordability program accepts application data and manages information in an "account" by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes.	There will not be any eligibility information coming directly from the Health Insurance Marketplace. The Agency will be DSS or DMAS. DMAS enrolls using the staff at the Xerox, Cover Virginia call center and CPU. It enrolls the MAGI people (the FFMs and the people who apply over the phone and the people who apply through Common Help).
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive enrollment determination from ***Determine Member Eligibility*** business process.	

EE Member Enrollment		
	Enroll Member	
Item	**Details**	**DMAS Differences/Comments**
	Environment-based Trigger Events to include but not limited to: • Receive presumptive eligibility determination from provider.	We only do presumptive eligibility for hospital as required by CMS per the ACA.
Result	• Enroll eligible member in Medicaid health plans and health benefits. • Alert sent to ***Manage Applicant and Member Communication*** to send welcome package, health plan, if applicable, health benefits, and identification cards. • Alert sent to send enrollment information to contractor. • If applicable, alert sent to ***Manage Member Financial Participation*** for premium payment arrangement. • Tracking information as needed for measuring performance and business activity monitoring.	Medicaid and FAMIS (CHIP) Welcome Package: Only Plan First and FAMIS Moms get welcome letters. Everyone gets a notice of action and their ID card. For all new enrollments, we send an 834 to appropriate contractors such as Service Auth, BHSA, MCOs, Dental, Transportation, CCC MMPs.
Business Process Steps	1. **START:** Receive eligibility determination to enroll member. 2. Agency associates member with elected health plan, if applicable, and health benefits. 3. Send alert to send enrollment information to contractor. 4. Send alert to send dual eligibility enrollment information to Medicare.	2. Members that have been determined eligible for full coverage are initially enrolled in Fee for Service. After the member is

EE Member Enrollment		
	Enroll Member	
Item	**Details**	**DMAS Differences/Comments**
	5. If applicable, send alert to ***Manage Member Financial Participation*** for premium payment arrangement. 6. **END:** Send notification to member with welcome package and identification cards via ***Manage Applicant and Member Communication*** business process.	enrolled there is a mid-month process that assigns eligible members to a health plan. If the member has chosen a health plan when they submitted their application then they get that health plan. If not, the system will assign them to a health plan. This is applicable to Managed Care (Medallion 3.0, CCC). 4. This is the Buy-in process. We send a file to CMS to notify them that we will be paying the Medicare Premiums. 5. There is no alert sent to ***Manage Member Financial Participation*** upon initial enrollment. The member applies for premium payment (HIPP or FAMIS Select). If the individual meets the requirements, they are manually enrolled for premium payment arrangement. This process occurs after

EE Member Enrollment		
Enroll Member		
Item	**Details**	**DMAS Differences/Comments**
		they have received notification of eligibility and their ID card.
Shared Data	Plan data store including policy information Health Benefit data store including benefit package and benefit information Member data store including demographics and application information Provider data store including provider network information Contractor data store including provider network information	A contractor's provider network is available through the contractor's website or a directory is available on request.
Predecessor	**Receive Inbound Transaction** *Determine Member Eligibility* ***Manage Applicant and Member Communication***	
Successor	**Send Outbound Transaction** ***Manage Applicant and Member Communication*** ***Manage Member Information*** ***Manage Member Financial Participation***	
Constraints	State may have different programs and different enrollment criteria, or may use enrollment brokers for some or all of the business process	We require all contractors to use the 834 transaction. We do

EE Member Enrollment		
Enroll Member		
Item	**Details**	**DMAS Differences/Comments**
	steps. States may require non-HIPAA covered contractors to use the ANSI X12 834 Benefit Enrollment and Maintenance transaction or may rely on State specific formats for contractor notification.	not use any state specific formats for contractor notification.
Failures	• Alert fails to reach member or contractor. • Duplicate enrollment requests, • Required field missing or not correct	
Performance Measures	• Time to complete process: successful applicant is enrolled within __ days • Accuracy of enrollment = _____% • Consistency of enrollments and disposition = _____% • Error rate is __% or less	Time to complete: same day as eligibility determination. Accuracy: Based on most recent report, VACMS 89.5% successful. Consistency…: VACMS generates a weekly report of enrollment transaction results. Error Rate: 13% or less Note: Above statistics are limited to VaCMS.

3.4.1.2.2 As-Is Assessment

The overall rating for the Enroll Member business process is '2.' DMAS and DSS undertook an Enrollment and Eligibility project that has moved the process to Level 3 in those areas that are supported through VaCMS, which is an enhanced eligibility determination and enrollment system jointly developed by DSS and DMAS that addresses the MITA Seven Standards and Conditions. While national standards and exchanges are used, the process still has some manual components and the transaction

error rate is higher than the Level 3 threshold.

Other items noted in the As-Is assessment were:

- Enrollments are real-time and notification is through X12 834 transactions
- There is no self-service for non-MAGI population
- VaCMS produces a weekly report of the results of enrollment transaction: the number successful and the counts by type of errors (e.g., invalid SSN, duplicate ID).

3.4.1.2.3 To-Be Assessment

DMAS intends to achieve Level 3 and move toward Level 4 for the Determine Member Eligibility business process.

Specific objectives include:

- Complete the migration of the Aged, Blind and Disabled Medicaid Covered Groups, including Long-term Care members to the VaCMS
- Complete the move to an automated business rules engine
- Increase electronic verification and automation of the application process
- Define and track performance measures.

These improvements should result in more consistent decision making, reduction of error rates, reduction of manual interventions and timeliness across programs and data sharing. Additionally, increased electronic verification and automation of the application process should increase member and provider satisfaction and expedite decision making.

3.4.1.2.4 Scorecard

The following scorecard was compiled for the Enroll Member business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
EE - Member Enrollment Enroll Member	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	3	3
Performance Measure		
Supporting Evidence Reference		

Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.4.1.3 Disenroll Member

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Disenroll Member business process.

3.4.1.3.1 Business Process Model

The Disenroll Member business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

EE Member Enrollment		
Disenroll Member		
Item	**Details**	**DMAS Differences/Comments**
	The ***Disenroll Member*** business process is	This business process covers what DMAS

EE Member Enrollment		
Disenroll Member		
Item	**Details**	**DMAS Differences/Comments**
Description	responsible for the termination of a member's enrollment in a health plan or health benefit. An enrollment termination may occur due to: • A member is no longer eligible based on redetermination of Medicaid eligibility either on an annual basis or as a result of change reporting during the coverage year. • Upon receipt of a notification of incarceration, SMA may suspend eligibility (if State policy indicates to do so). • A member is no longer eligible based on change in residence. • The denial of eligibility for a benefit that is based on a technical factor or non-financial characteristic. • A member submits a disenrollment request. • Disenrollment request from a provider or contractor due to issues with the member such as moving out of service area, fraud and abuse, disruptive behavior, non-compliance, or death. • Member is deceased. • Receive disenrollment request from ***Manage Compliance Incident Information*** business process for continued failure to make payments. • Receive disenrollment request from ***Determine Adverse Action Incident*** due to fraudulent or abuse activity. • The provider or contactor has a change of status or termination that requires a mass disenrollment of members. • A health plan or health benefit has a change that requires a mass disenrollment of members. • A member modifies their Manage Care Organization (MCO), Primary Care Case Manager (PCCM), or waiver provider:	refers to as 're-assignment' rather than disenrollment in some cases. Eligibility suspension for incarceration not done Only if moved out of state Failure to make payments does not cause disenrollment Provider changes do not cause disenrollment This would be a re-assignment not disenrollment This would be a re-assignment not

EE Member Enrollment		
Disenroll Member		
Item	**Details**	**DMAS Differences/Comments**
	○ Member changes information during Open Enrollment period. ○ As permitted by State rules, such as the following: ✓ Change in member's residence. ✓ A provider whom the member has chosen no longer contracts with current program or MCO. ✓ Medicaid terminates the contract with the member's MCO or PCCM. ✓ Member successfully appeals auto-assignment. ✓ The member has issues with the MCO, PCCM, or waiver provider that may affect quality of care. **NOTE:** Enrollment brokers may perform some of the steps in this business process.	disenrollment DMAS does not have a PCCM program
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive disenrollment request from insurance affordability program. • Receive disenrollment request from ***Manage Compliance Incident Information*** business process for continued failure to make payments. • Receive disenrollment request from ***Determine Adverse Action Incident*** business process to remove member from services. Environment-based Trigger Events to include but not limited to: • Receive disenrollment request from member, provider or contractor. • Change in member's information that no longer meets eligibility criteria.	This is not applicable This is not applicable

EE Member Enrollment		
Disenroll Member		
Item	**Details**	**DMAS Differences/Comments**
	• Member modifies their selection of provider, MCO, PCCM or waiver provider. • Provider or contractor modifies network information that alters their service offering. • Modifications in health plan or health benefit that alters service offering.	
Result	• Member disenrolled from specific health plans and health benefits. • Member disenrolled from elected provider or contractor. • Alert sent to ***Manage Applicant and Member Communication*** business process to notify member of disenrollment and fair hearing/procedural rights. • Alert sent to ***Perform Population and Member Outreach*** business process to notify affected members with the termination of health plan, health benefit, a provider or a contractor. • Alert sent to send disenrollment information to insurance affordability program. • If applicable, alert sent to ***Manage Member Financial Participation*** to stop premium payment arrangement. • If applicable, alert sent to ***Manage Case Information*** to discontinue care management. • Tracking information as needed for measuring performance and business activity monitoring.	Actually, re-assigned unless disenrolled from Medicaid or FAMIS No notice is sent for re-assignments; a referral is sent to marketplace for loss of eligibility due to excess income or no longer meeting a covered group

EE Member Enrollment		
Disenroll Member		
Item	**Details**	**DMAS Differences/Comments**
Business Process Steps	1. **START:** Receive disenrollment request.	
	2. Agency logs disenrollment request including source of disenrollment and type of request.	
	3. Validate request meets State disenrollment rules.	
	4. If applicable, terminate enrollment in Medicaid health plans and/or health benefits.	We 're-assign' versus disenroll/enroll in some cases
	5. If applicable, go to ***Enroll Member*** to enroll member in alternative health plans and/or health benefits.	
	6. If applicable, terminate enrollment with provider or contractor.	
	7. If applicable, enroll member with alternative provider or contractor.	
	8. Send alert to ***Manage Applicant and Member Communication*** business process to notify member of disenrollment and procedural rights.	
	9. Send alert to ***Perform Population and Member Outreach*** business process to notify affected members with the termination of health plan, health benefit, a provider or a contractor.	
	10. If applicable, send alert to ***Manage Member Financial Participation*** to stop premium payment arrangement.	No alert is sent as process is manual
	11. If applicable, send alert to ***Manage Case Information*** to discontinue care management.	See note above
	12. Send alert to send disenrollment information to insurance affordability program.	
	13. END	

EE Member Enrollment		
Disenroll Member		
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Member data store including demographics and eligibility information Plan data store including health policy information Health Benefit data store including benefit package and benefit information Provider data store including provider network information Contractor data store including provider network information	DMAS does not use/access contractor's provider network information
Predecessor	**Receive Inbound Transaction** ***Determine Member Eligibility*** ***Manage Member Information*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Provider Information*** ***Manage Contractor Information*** ***Manage Compliance Incident Information*** ***Determine Adverse Action Incident***	Not applicable; not disenrolled due to failure to make payment
Successor	**Send Outbound Transaction** ***Enroll Member*** ***Manage Member Information*** ***Manage Applicant and Member Communication*** ***Manage Case Information*** ***Manage Contractor Communication*** ***Manage Member Financial Participation*** ***Manage Provider Information***	

EE Member Enrollment		
Disenroll Member		
Item	**Details**	**DMAS Differences/Comments**
	Manage Provider Communication ***Perform Population and Member Outreach***	
Constraints	Programs have different termination criteria.	
Failures	• Duplicate disenrollment requests — Disregard second request. • Required fields missing or not correct — Request additional or corrected information from member, provider, contractor, Health Insurance Marketplace, or insurance affordability program. • Denial of member request for disenrollment from one health plan, health benefit, provider or contractor due to modifications in circumstances, such as residence, health status, or provider access issues because the request does not meet State rules or the member is not eligible for enrollment in an alternative program. • Denial of program, provider, or contractor request to disenroll the member (e.g., modified residence, health status or compliance issues because the request does not meet State rules).	DMAS does not request additional information from Health Insurance Marketplace, or insurance affordability program.
Performance Measures	• Time to complete process: member is disenrolled within ____days or ___ minutes • Accuracy of decisions • Consistency of decisions and disposition = ____% • Error rate is ___% or less	Varies based on reason and type Strive for 100% but not measured Strive for 100% but not measured Unknown

3.4.1.3.2 As-Is Assessment

The overall rating for the Disenroll Member business process is '2.' DMAS and DSS undertook an Enrollment and Eligibility project that has moved the process to Level 3 in those areas that are supported through VaCMS, which is an enhanced eligibility determination and enrollment system jointly developed by DSS and DMAS. While national standards and exchanges are used, the process still has some manual components and the transaction error rate is higher than the Level 3 threshold.

Other items noted in the As-Is assessment were:

- DMAS does not disenroll a member due to a change in eligibility or health plan, etc.; in such cases the member is 'reassigned'
- The accuracy of the process results are enhanced because DMAS uses the X12 834 to communicate disenrollments.

3.4.1.3.3 To-Be Assessment

DMAS intends to achieve Level 3 and move toward Level 4 for the Disenroll Member business process.

Specific objectives include completion of the Enrollment and Eligibility Project, in those areas supported through VaCMS, which will progress the rating toward Level 4

These improvements should result in improvements in the overall processes surrounding national standards and exchanges, by reduction in manual components and error rate should move business processes toward the Level 4 threshold.

3.4.1.3.4 Scorecard

The following scorecard was compiled for the Disenroll Member business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
EE - Member Enrollment Disenroll Member	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3

Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.4.1.4 Inquire Member Eligibility

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Inquire Member Eligibility business process.

3.4.1.4.1 Business Process Model

The Inquire Member Eligibility business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

EE Member Enrollment		
Inquire Member Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	The ***Inquire Member Eligibility*** business process receives requests for eligibility	For Marketplace, the

EE Member Enrollment		
Inquire Member Eligibility		
Item	**Details**	**DMAS Differences/Comments**
Description	verification from Health Insurance Marketplace, authorized providers, programs or business associates; performs the inquiry; and prepares the Eligibility, Coverage or Benefit Information response. The response information includes but is not limited to benefit status, explanation of benefits, coverage, effective dates, and amount for co- insurance, co-pays, deductibles, exclusions and limitations. The information may include details about the Medicaid health plans, health benefits, and the provider(s) from which the member may receive covered services. **NOTE:** This business process does not include Member requests for eligibility verification. Member initiated requests are handled by the ***Manage Member Information and or Manage Applicant and Member Communication*** business processes.	response is limited to yes/no regarding minimum essential coverage (MEC). DMAS does not provide information regarding provider(s) from which the member may receive covered services.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive eligibility inquiry from the Health Insurance Marketplace via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 Inquiry transaction using the Council for Affordable Healthcare (CAQH®) Committee on Operating Rules for Information Exchange (CORE®) Phase 1 and 2 Rules. • Receive eligibility inquiry from the provider via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 inquiry transaction using CAQH CORE Rules. • Receive eligibility inquiry from the pharmacist via National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Eligibility transaction.	

EE Member Enrollment		
Inquire Member Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	• Receive eligibility inquiry via Automated Voice Response System (AVRS) or other commonly available electronic means.	
Result	• Response sent to Health Insurance Marketplace via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules. • Response sent to provider via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules. • If applicable, response sent to AVRS or other commonly available electronic means with eligibility information. • Tracking information as needed for measuring performance and business activity monitoring.	DMAS is self-certified regarding CAQH/CORE requirements.
Business Process Steps	1. **START:** Receive eligibility verification request. 2. Agency logs eligibility verification request. 3. Validate requester's authorization to receive requested information. 4. Find requested member's eligibility information. 5. Agency logs response. 6. If applicable, send response to AVRS with eligibility information.	

EE Member Enrollment		
Inquire Member Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	7. **END:** Send response to requestor via ANSI X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 271 Response transaction using CAQH CORE Rules.	
Shared Data	Member data store including demographics, eligibility and enrollment information	
Predecessor	**Receive Inbound Transaction**	
Successor	**Send Outbound Transaction**	
Constraints	Eligibility verification request can ask for verification at the categorical, health plan, provider, or health benefit level per X12 Health Care Eligibility Benefit Inquiry and Response (270/271) 270 Inquiry depending on trading partner agreements. Agency must use Council for Affordable Healthcare (CAQH®) Committee on Operating Rules for Information Exchange (CORE®) Phase 1 and 2 Rules in addition to other HIPAA compliant inquiry methods.	
Failures	• Unauthorized requestor cannot receive requested information at the level asked (e.g., eligibility for mental health program); however, requester may receive more general information such as verification of eligibility for health plan or health benefit coverage. **NOTE:** Responses that a member is not eligible or is not active are not failures to process the request.	

EE Member Enrollment		
Inquire Member Eligibility		
Item	**Details**	**DMAS Differences/Comments**
Performance Measures	• Time to verify eligibility and generate response: e.g., Real Time response = within___seconds, Batch Response = within ____hours • Response Accuracy = ____% • Error rate =___% or less • Usage of CORE certified response = ____% of the time	CORE requirements are met or exceeded

3.4.1.4.2 As-Is Assessment

The overall rating for the Inquire Member Eligibility business process is '3.' This process is entirely automated, uses the HIPAA and CORE standards and operating rules, and is accurate.

Other items noted in the As-Is assessment were:

- Providers that may be available to members are not returned as part of the member eligibility responses
- The information returned is 100% accurate in that it consistently returns the data stored in the database, but we left Data Access and Accuracy rating as '3.'

3.4.1.4.3 To-Be Assessment

The Inquire Member Eligibility business process is currently performing at a solid Level 3, however some improvements have been identified.

Specific objectives for improvement include:

- Increased use of automation
- Completion of movement toward business rules engine
- Strengthening performance measures
- Enhancement of web-based and AVRS systems.

These improvements should begin to evolve the Inquire Member Eligibility business process toward Level 4 capabilities by further improving efficiency and performance measures.

3.4.1.4.4 Scorecard

The following scorecard was compiled for the Inquire Member Eligibility business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
EE - Member Enrollment Inquire Member Eligibility	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	3	3
Timeliness of Process	3	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	4
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	3	4
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	4
Performance Measure		
Supporting Evidence Reference		

3.4.2 Provider Enrollment

As shown in Figure 3.4-1, the Provider Enrollment business category is made up of four business processes:

- Determine Provider Eligibility
- Enroll Provider
- Disenroll Provider
- Inquire Provider Eligibility.

Details regarding the assessment of each Provider Enrollment business process follow.

3.4.2.1 Determine Provider Eligibility

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Determine Provider Eligibility business process.

3.4.2.1.1 Business Process Model

The Determine Provider Eligibility business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Determine Provider Eligibility*** business process collects enrollment application from Health Care Provider, or collects re-enrollment or revalidation information from existing Provider. The business process verifies syntax and semantic of information, checks status tracking (e.g., initial, modification, duplicate, cancelation), requests additional information when necessary, determines screening level (i.e., limited, moderate or high), verifies applicant information with external entities, collects application fees, and notifies Health Care Provider or Provider of enrollment eligibility	DMAS performs all of these functions. DMAS uses other states screenings if done within the past 12 months, part of PSR.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	determination (e.g., accepted, denied, or suspended). ***Determine Provider Eligibility*** business process sends enrollment determination alert signals to subscribing business processes ***Enroll Provider*** and ***Manage Provider Communication.*** ***Determine Provider Eligibility*** sends alert signal to ***Manage Accounts Receivable Funds*** business process to collect application fee. The ***Determine Provider Eligibility*** business process works in conjunction with Medicare and the processing of dual eligibles. Medicare agency conducts provider screening activities, application fee collection, and revalidation for those providers who are dual eligible. ***Determine Provider Eligibility*** business process is responsible for the provider screening activities, application fee collection, and revalidation for only Medicaid providers. **NOTE:** External contractors such as quality assurance and credentialing verification services may perform some of these steps.	No outside contractors used other than Fiscal Agent.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive the following from either a Health Care Provider or existing Provider: o Requester completes enrollment application information (e.g., Provider name, Provider address, Provider National Provider Identifier (NPI), etc.).	Application Fee limited to certain provider types as defined in the Provider Enrollment procedure manual.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	○ Requestor resubmits enrollment application information. ○ Requestor modifies or cancels application. ○ Disenrolled Provider submits re-enrollment application information. ○ Requestor submits additional information in support of an enrollment application. • Periodic review is due or receipt of request to: ○ Determine revalidation of credentials. Revalidation takes place every five (5) years except for Durable Medical Equipment Prosthetic, Orthotics & Supplies which is every three (3) years; revalidation also requires an application fee. ○ Monitor sanctions applied to a Provider. ○ Assist in program integrity review.	Disenrolled providers must submit a new application. All providers are reviewed every 5 years, including DME.
Result	• Agency accepts, denies, or suspends the requestor's application. • Agency notifies the requestor of enrollment eligibility (i.e., accepted, denied or suspended). • Alert sent to ***Enroll Provider*** business process to assign contracting • parameters; establish payment rates and other activities for eligible requestor. • Alert sent to ***Manage Accounts Receivable Funds*** business process to • collect application fee. • If applicable, alert sent to ***Disenroll Provider*** business process to remove provider from services. • Alert sent to notify provider via ***Manage Provider Communication*** business process of enrollment eligibility	DMAS uses the term PEND as opposed to SUSPEND for missing information on a new application. DMAS REJECTs for missing information on a re-validation. Provider did not submit all of the needed information; provider can add missing information and resubmit. DENIAL, provider must appeal in order to possibly be approved. DMAS does not send any notifications to Medicare.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	determination. • If applicable, alert sent to notify Medicare of both dual eligible and regular Medicaid providers information. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Health Care Provider completes and submits an enrollment application or existing Provider submits enrollment application for revalidation. 2. Requestor identifies Office of the National Coordinator for Health Information Technology (ONC) Authorized Testing and Certification Body (ATCB) certification for electronic health record incentive. 3. Requestor identifies if they are currently participating in Medicare or Children's Health Insurance Program (CHIP). If yes, skip to step 14. 4. Requestor selects application fee payment option including designation of hardship or exclusions from payment. 5. Requestor provides appropriate payment information. 6. Receive enrollment application and other pertinent enrollment communication information. 7. Validate application syntax/semantic conformance. a. **END:** If validation fails, business process stops (see Failures).	#2 is not part of the DMAS enrollment process, not a condition of our provider enrollment. It is performed by a separate contractor, CGI. CGI and Myers & Stauffer validate that the provider has met criteria for EHR to qualify for financial incentives.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	8. If necessary, request missing information from requestor. Go step 14. 9. Determine submission status by querying the Provider data store. Application status may be initial, resubmitted with modification, or duplicate. a. If resubmitted application, message contains only updated information and process may skip irrelevant steps below. b. **END:** If duplicate application, produce result messages and stop business process (see Failures). c. Other communications may be requests to cancel application, and to deactivate or reactivate enrollment. 10. Determine applicant type/Provider taxonomy (e.g., primary, rendering, pay to, billing, or other). 11. Determine designated categorical risk (e.g., limited, moderate, or high) based on provider/supplier's category. 12. Assess categorical risk to determine appropriate required screening level. a. Limited Risk includes: i. Verification of any provider/supplier-specific requirements established by Medicare ii. License verifications (may include licensure checks across state) iii. Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the	#10 is not part of our enrollment process. Taxonomy is based on the provider type and specialty, which is mapped to a Taxonomy code in VAMMIS. Ordering/Referring/Prescribing (ORP) only designated as program code 11. #12.a.iii: Database Checks performed are SSA-DMF; NPPES for NPI; OIG-LEIE; EPLS; and MCSIS. No check for tax delinquency.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	National Practitioner Data Bank (NPDB) licensure, an Office of the Inspector General (OIG) exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	No check against NPDB.
	b. Moderate Risk includes: i. Inclusion of Limited Risk screening ii. Unscheduled or Unannounced Site Visits	
	c. High Risk includes: i. Inclusion of Moderate Risk screening ii. Criminal Background Check iii. Fingerprinting	High Risk and Moderate Risk are handled the same way; no Criminal Background Check or Fingerprinting performed.
	13. Conduct screening based on required screening level with automated transactions except where manual verification if necessary.	
	14. Determine enrollment eligibility (e.g., accepted, denied, or suspended) based on federal and state rules.	#14. Can also be rejected.
	15. Determine if there are enrollment caps due to moratoriums issued. If yes, skip to step 19.	#15. DMAS has this capability but we have not had occasion to do this yet.
	16. If Medicaid accepts enrollment application, send alert to ***Enroll Provider*** business process to assign contracting parameters, establish payment rates, and other activities for eligible requestor.	
	17. Alert sent to ***Manage Accounts***	

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	Receivable Funds business process to collect application fee. 18. If Medicaid denies the enrollment application for existing Provider, send alert to ***Disenroll Provider*** business process to remove provider from services. 19. If applicable, send alert to notify Medicare of both dual eligible and regular Medicaid providers information. 20. **END:** Send enrollment eligibility determination to ***Manage Provider Communication*** business process to send relevant information to requestor. Alternate Business Process Path: ***Determine Provider Eligibility*** business process results in a denial or suspension of an enrollment eligibility request for reasons such as: · Requestor fails to meet screening requirements. · Requestor fails to meet state enrollment requirements. · National Plan and Provider Enumeration System (NPPES) or any other national enumeration systems cannot enumerate Health Care Provider.	#19. DMAS does not send alert to Medicare. Alternate Business Process Path: ***Determine Provider Eligibility*** business process can also result in a rejection.
Shared Data	Centers for Medicare & Medicaid Services (CMS) Medicare Dual Eligible Provider data store Provider data store including application information (NPI, Provider demographics,	DMAS does not share Provider data with CMS.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	Provider taxonomy) NPI and Provider demographics exchanged with the National Plan and Provider Enumeration System (NPPES) and any other national enumeration systems Provider sanction information from: · The OIG or the General Accounting Office (GAO) sanction lists of individuals, vendors, and/or suppliers excluded from participation in Medicare, Medicaid, and other federally funded Sate programs from databases such as the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). · State Provider Licensing Authority · Healthcare Integrity and Protection Data Bank (HIPDB) data store · National Practitioner Databank (NPDB) · State Prescription Monitoring Program (PMP) Tax identifiers: Employer ID Number (EIN), Social Security Number (SSN), Taxpayer Identification Number (TIN) from applicant and verified with tax identifier verification sources and any other information required for Form 1099 production Disclosure information including: · Information on ownership and control	DMAS does not share data with HIPDB or NPDB. DMAS verifies this information using the W-9 form.

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	· Information related to business transactions · Information on persons convicted of crimes · Disclosure by providers and State Medicaid agencies. Multiple office locations, pay to addresses, business associates, and key contract personnel CMS caps and limits moratorium information Insurance Affordability Program data store including eligibility and enrollment information	DMAS does not maintain caps and limits moratorium information. DMAS does not share data with the Insurance Affordability Program.
Predecessor	**Receive Inbound Transaction**	
Successor	***Manage Accounts Receivable Funds*** ***Enroll Provider*** ***Disenroll Provider*** ***Manage Provider Communication***	
Constraints	The Provider application process will accommodate the full range of Provider types, organizations, specialties, different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., solo office practice, group practice, rural health clinic); as well as, appropriate applications (e.g., New, Modification, Cancellation, Update). Different business rules may apply to each of these different types. Affiliations –	DMAS does not capture Subpart relationships. We do capture MCO

EE Provider Enrollment		
Determine Provider Eligibility		
Item	**Details**	**DMAS Differences/Comments**
	Managed Care Organization (MCO) or subpart relationship.	Affiliations.
Failures	Enrollment application processing terminates or suspends due to: · Duplicate or cancelled applications. · Failure to validate application edits. · Requires additional information to process application.	Application is also suspended if an application fee is required but not received.
Performance Measures	· Time to complete Enrollment process = within __ days · Accuracy with which edits are applied = ___% · Consistency of decisions and disposition = ___% · Error rate = __% or less	· 10 days · 98% (98% percent of applications processed with a 100% accuracy) · N/A · 0% (on 98% of applications)

Provider Enrollment Variations			
Type	**Type Subtypes**	**Information**	**DMAS Differences/Comments**
Institutional Provider	The Institutional Provider application will accommodate a range of institutional Provider types (e.g., inpatient, nursing home, day care), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., outpatient, emergency room, assisted living).	NPI, entity type, taxonomy, type of facility, bed size, equipment, type of institutional services, ownership, trading partner information, billing and payment information, tax code, Diagnosis Related Group (DRG) or other payment type	
Individual Provider	The Individual Billing Provider application will accommodate a range of professional billing Provider types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other).	NPI, entity type, taxonomy, affiliation, location, trading partner information, billing and payment information	
Individual Rendering Provider	The Individual Rendering Provider application will accommodate a range of professional rendering Provider types (e.g. Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology,	NPI, entity type, taxonomy, affiliation, location, equipment	

	other) Enumerate a group health practice separately from the individual physicians associated with it.		
Pharmacy	The Pharmacy application will accommodate a range of types (e.g., major chain with hundreds of stores, community pharmacy), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., retail store, outpatient facility, nursing home). **NOTE:** The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist.	NPI, entity type, ownership, location, unit dose, mail order, Drug Enforcement Administration (DEA) information, Drug Utilization Review (DUR) compliance, trading partner information, billing and payment information	DMAS does not collect unit dose, mail order, DEA information, or DUR compliance.
Atypical	The atypical Provider application will accommodate a range of types of programs (e.g., waiver, assistance in the home), different kinds of service Providers (e.g., family caretaker, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., in the home, day care center). **NOTE:** The NPI	Provider ID, SSN, specialty, type of service Provider, allowed services, invoicing method	

	enumeration does not provide ID numbers for atypical Providers at this time.		
Suppliers	The DME suppliers and manufacturers supply or manufacturers application will accommodate a range of durable medical equipment, prosthetics, orthotics, supplies (DME Ops) types.	NPI, entity type, EIN, DME license, supplies, trading partner information, billing and payment information, ownership	
Medical Transportation	The Medical Transportation Provider application will accommodate a range of transportation modes that include Air, Ambulance, Law, Pedestrian, Private or Public Transport. It should accommodate different types of vehicles, aircraft, licensing, and inspection information.	EIN, entity type, license type and number, inspection, vehicle, aircraft, and/or ambulance information	

3.4.2.1.2 As-Is Assessment

The overall rating for the Determine Provider Eligibility business process is '2.' While Direct Data Entry of applications is supported, about 50% of current applications are submitted on paper. There are no edits in the work flow. A **Provider Enrollment Procedure Manual** provides details about the process.

Other items noted in the As-Is assessment were:

- External data verifications include:
  - Excluded Parties List System (EPLS)
  - Death Master File (DMF)
  - List of Excluded Individuals/Entities (LEIE)
  - National Plan and Provider Enumeration System (NPPES)
  - Medicaid and Children's Health Insurance Program State Information Sharing (MCSIS)

  - Department of Health Professionals
- The average time to process an application approaches 30 days for all steps
- All applications are screened automatically
- Performance standards are reviewed weekly and are consistently being met
- Providers feedback is sought on a regular basis.

3.4.2.1.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Determine Provider Eligibility business. This includes:

- Exceeding state and federal requirements for fully automated and timely provider enrollment application processing, one-stop collaboration across SMA including dual-eligibility with Medicare and CHIP as well as enhancing background check and screening by level of risk with federal agencies
- Standardizing enrollment application interfaces and incorporating other nationally recognized standards for intrastate exchange of information
- Fully automating all federal screening requirements of low, medium and high risk providers within the intrastate
- Automatically verifying information submitted with reduced manual verifications
- Automating business rules engines for enrollment application standard messages to create definitions for consistent validation
- Automatically revalidating provider credentials within the intrastate, receiving alerts when adverse results occur
- Improving timeliness via state and federal collaboration, use of enrollment application information sharing, standards, and regional information exchange hubs
- Achieving performance benchmarks.

3.4.2.1.4 Scorecard

The following scorecard was compiled for the Determine Provider Eligibility business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
EE - Provider Enrollment Determine Provider Eligibility	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		

Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.4.2.2 Enroll Provider

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Enroll Provider business process.

3.4.2.2.1 Business Process Model

The Enroll Provider business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

EE Provider Enrollment
Enroll Provider

Item	Details	DMAS Differences/Comments
Description	The ***Enroll Provider*** business process is responsible for enrolling providers into Medicaid that includes: ▪ Determination of contracting parameters (e.g., Provider taxonomy, type, category of service that the Provider can bill). ▪ Establishment of payment rates and funding sources, taking into consideration service area, incentives or discounts. NA ▪ Alert sent to ***Manage Contract*** business process to negotiate contracts. ▪ Supporting receipt and verification of program contractor's Provider enrollment roster information (e.g., from Managed Care Organization (MCO) and Home and Community-Based Services (HCBS)). ▪ Alert sent to ***Manage Provider Information*** business process to load initial and modified enrollment information, including Providers contracted with program contractors into the Provider data store. ▪ Alert sent to ***Manage Provider Information*** business process to provide timely and accurate notification, or to make enrollment information required for operations available to all parties and affiliated business processes, including: o Alert sent to ***Prepare Provider Payment*** business process for capitation and premium payments. o To prepare Provider Electronic Funds Transfer (EFT) or check with the ***Manage Accounts Payable Disbursement*** business process.	Providers of service, i.e., billing, servicing, referring providers, etc., sign Participation Agreements, but are not considered contractors. DMAS creates a provider record in VAMMIS for every contractor we have so they can be paid. A special class type/program code is used. MCOs, Dental ASO, the Behavioral Health ASO, and Transportation contractor send DMAS spreadsheets of provider data which are manually entered into VAMMIS as program 10s. There are no HCBS vendors that send provider data.

EE Provider Enrollment		
Enroll Provider		
Item	**Details**	**DMAS Differences/Comments**
	○ The appropriate communications and outreach processes for follow-up with the affected parties, including informing parties of their procedural rights. • Periodic review is due or receipt of request to: ○ Negotiate payment rates. ○ Notify Provider of enrollment determination. ***Enroll Provider*** business process supports receipt and verification of program contractor's Provider enrollment roster information (e.g., name, identification, contract information, type, specialty and services) from Managed Care Organization (MCO) and HCBS organizations.	
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive newly eligible Provider from ***Determine Provider Eligibility*** business process. • Receive newly eligibility contractor from ***Award Contract*** business process. • Receive alert from ***Manage Performance Measures*** to revalidate provider. Environment-based Trigger Events to include but not limited to: • Periodic review is due or receipt of to: ○ Renegotiate payment rates. ○ Reevaluate enrollment based criteria such as performance measures, or triggered by date such as anniversary date based on Medicaid policy to verify information based on a contractual duration (e.g. year or months).	Reports provided based on 30, 60, 90 day to cancellation. DMAS does not negotiate rates with providers.

EE Provider Enrollment		
	Enroll Provider	
Item	**Details**	**DMAS Differences/Comments**
	• Receive program enrollment or disenrollment information from Medicaid or CHIP. • Receive request for provider's enrollment roster information.	DMAS produces reports for groups of member providers.
Result	• Enrolled, re-enrolled, suspended, or denied enrollment of provider or contractor into programs. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of enrollment determination. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of enrollment determination. • If applicable, alert sent to ***Manage Contractor Payment*** for payment arrangement. • Alert sent to ***Perform Provider Outreach*** to send relevant state policy information. • Alert sent to ***Manage Contract*** business process to negotiate contract. • If applicable, send response for Provider enrollment roster information. • Alert sent to notify Health Insurance Marketplace of provider enrollment information. • Tracking information as needed for measuring performance and business activity monitoring.	DMAS does not send alerts to Health Insurance Marketplace

EE Provider Enrollment		
	Enroll Provider	
Item	**Details**	**DMAS Differences/Comments**
Business Process Steps	1. **START:** Determine contracting parameters (e.g., Provider taxonomy, categories of service for which the Provider can bill), eligible Provider types, payment types, contract terms and maximums, member enrollment levels, panel size, and any contractor specific benefit packages and procedures. 2. Assign any identifiers used internally. 3. Determine if there are enrollment limits due to moratoriums issued. If yes, skip to step 9. 4. Assign to programs and determine rates: Includes identifying type of rate (e.g., negotiated, Medicare, percent of charges, case management fee, other via look-ups in the reference and benefit repositories). 5. If applicable, send alert to ***Manage Contractor Payment*** business process for payment arrangement. 6. Send alert to ***Perform Provider Outreach*** business process to send relevant state policy information. 7. Send alert to ***Manage Contract*** business process to negotiate contract. 8. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of enrollment determination. 9. If applicable, provide response to request for Provider enrollment roster information. 10. Send alert to notify Health Insurance	DMAS assigns a provider class type and specialty. The standard taxonomy codes are only used for a subset of providers, about 20 class types. DMAS instructs the providers which taxonomy code to use when it is needed. #7 and 8 are not applicable to providers of service, only contractors. #10 DMAS does not send alerts to Health Insurance

EE Provider Enrollment		
Enroll Provider		
Item	**Details**	**DMAS Differences/Comments**
	Marketplace of provider enrollment information. **END:** Send alert to notify provider via ***Manage Provider Communication*** business process of enrollment determination.	Marketplace

Shared Data	Provider data store including:
	• Provider demographics
	• Provider network
	• Contract information
	  o Type
	  o Specialty
	  o Enrolled Program
	  o Jurisdiction
	  o Payment Information
	• Provider taxonomy
	• Service Location Information
	  o Category of Service
	  o Services
	  o Limitations
	  o Business Arrangement
	• Contractor data store including provider network information
	• Plan data store including health
		Provider taxonomy is used on a limited basis
		
		Provider network information is maintained for MCOs.

EE Provider Enrollment		
	Enroll Provider	
Item	**Details**	**DMAS Differences/Comments**
	benefit and fees information • Moratorium data store including Caps and Limits information • Health Insurance Marketplace including provider enrollment information	DMAS does not currently store Caps and Limits information, but the system supports using them DMAS does not share information with the Health Insurance Marketplace
Predecessor	**Determine Provider Eligibility** **Manage Provider Communication** **Manage Performance Measures** **Award Contract**	Award Contract only applies to MCOs and other contractors that are added to the Provider data store
Successor	***Manage Provider Information*** ***Manage Provider Communication*** ***Manage Contractor Information*** ***Manage Contractor Communication*** ***Perform Provider Outreach*** ***Manage Contract***	Providers of service sign Provider Agreements. Manage Contractor Information and Communication and Manage Contract only apply to MCOs and other contractors that are added to the Provider data store.

EE Provider Enrollment		
Enroll Provider		
Item	**Details**	**DMAS Differences/Comments**
Constraints	The Provider enrollment process will accommodate the full range of Provider types, organizations, specialties, different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., solo office practice, group practice, rural health clinic) as well as different types of applications (e.g., New, Modification, Cancellation, Update). Different business rules may apply to each of these different types. Affiliations – MCO or subpart relationship. .	Assume 'billing agent' is a billing group. DMAS does not enroll service centers or clearinghouses as a provider. DMAS does not maintain subpart relationships.
Failures	***Enroll Provider*** business process results in a denied or suspended enrollment request for reasons such as: • Lack of applicable rates. • Provider meets caps or limits moratorium.	DMAS provides all rate information Missing key information can result in denial or suspension
Performance Measures	- Time to complete Enrollment process = within _ days - Accuracy with which edits are applied = _____% - Consistency of decisions and disposition =____% - Error rate =_____% or less	• 10 days • 100% accurate 98% of the time • Not measured • 0% errors 98% of the time

Provider Enrollment Variations			
Type	**Subtypes**	**Information**	**DMAS Differences/Comments**
Institutional Provider	The Institutional Provider application will accommodate a range of institutional Provider types (e.g., inpatient, nursing home, day care), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., outpatient, emergency room, assisted living).	NPI, entity type, taxonomy, type of facility, bed size, equipment, type of institutional services, ownership, trading partner information, billing and payment information, tax code, DRG or other payment type	
Individual Provider	The Individual Billing Provider application will accommodate a range of professional billing Provider types (e.g., Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other).	NPI, entity type, taxonomy, affiliation, location, trading partner information, billing and payment information	
Individual Rendering Provider	The Individual Rendering Provider application will accommodate a range of professional rendering Provider types (e.g. Physician, Osteopath, Podiatrist, Chiropractor, Clinic, Lab, Radiology, other) Enumerate a group health practice separately from the individual physicians associated with it.	NPI, entity type, taxonomy, affiliation, location, equipment	
Pharmacy	The Pharmacy application will	NPI, entity type, ownership, location,	DMAS does not collect unit dose, mail order, DEA

	accommodate a range of types (e.g., major chain with hundreds of stores, community pharmacy), different types of applicants (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., retail store, outpatient facility, nursing home). **NOTE:** The NPI enumeration will give one number to the individual drug store. It does not enumerate the individual pharmacist	unit dose, mail order, DEA information, DUR compliance, trading partner information, billing and payment information	information, or DUR compliance.
Atypical	The atypical Provider application will accommodate a range of types of programs (e.g., waiver, assistance in the home), different kinds of service Providers (e.g., family care- taker, taxi cab, plumber, carpenter, meals on wheels), different types of relationships (e.g., the primary Provider, billing agent, pay-to entity), and care settings (e.g., in the home, day care center). **NOTE:** The NPI enumeration does not provide ID numbers for atypical Providers at this time.	Provider ID, SSN, specialty, type of service Provider, allowed services, invoicing method	
Suppliers	The DME suppliers and manufacturers supply or manufacturers application will accommodate a range of durable medical equipment, prosthetics,	NPI, entity type, EIN, DME license, supplies, trading partner information, billing and payment information,	

	orthotics, supplies (DME Ops) types.	ownership	
Medical Transportation	The Medical Transportation Provider application will accommodate a range of transportation modes that include Air, Ambulance, Law, Pedestrian, Private or Public Transport. It should accommodate different types of vehicles, aircraft, licensing, and inspection information.	EIN, entity type, license type and number, inspection, vehicle, aircraft, and/or ambulance information	

3.4.2.2.2 As-Is Assessment

The overall rating for the Enroll Provider business process is '2.' Direct Data Entry is supported but some processes are manual, and 50% of applications are submitted via paper. Performance standards are consistently met or exceeded.

Other items noted in the As-Is assessment were:

- The NPI is consistently used, but State-specific Atypical Provider Identifiers (API's) are assigned for non-healthcare providers
- Billing agents, also known as clearinghouses or service centers, are not enrolled as providers
- Performance standards are reviewed weekly and are consistently being met
- Provider feedback is sought on a regular basis.

3.4.2.2.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Enroll Provider business process. This includes:

- Widespread sharing of the provider network including with the state Health Insurance Marketplace
- Standardizing enrollment interfaces and incorporating other nationally recognized standards for intrastate exchange of information
- Providing the capability for providers to submit a nationally standardized enrollment application from any location that has internet access
- One stop collaboration across multiple intrastate programs, such as Medicaid, Medicare, and CHIP
- Collaborating with other intrastate agencies to adopt national standards and to develop and share reusable business services
- Improving timeliness via state and federal collaborations, use of enrollment assignment, information sharing standards, and regional information

3.4.2.2.4 Scorecard

The following scorecard was compiled for the Enroll Provider business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
EE - Provider Enrollment Enroll Provider	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.4.2.3 Disenroll Provider

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Disenroll Provider business process.

3.4.2.3.1 Business Process Model

The Disenroll Provider business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

EE Provider Enrollment		
Disenroll Provider		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Disenroll Provider*** business process is responsible for managing disenrollment in the Medicaid Program. This business process covers the activity of disenrollment including the tracking of disenrollment requests and validation that the disenrollment meets state's rules. Medicaid sends notifications to affected parties (e.g., provider, contractor, business partners) as well as alerts to other business processes to discontinue business activities.	
Trigger Event	Interaction-based Trigger Events: • Receive disenrollment from insurance affordability program. • Receive disenrollment from ***Determine Provider Eligibility*** business process within ineligible information. • Receive disenrollment from ***Manage Compliance Incident Information*** business process for continued failure to make payments. • Receive disenrollment from ***Manage Provider Information*** business process from provider request. • Receive disenrollment from ***Manage Contractor Information*** business process from contractor request. • Receive alert from ***Determine Adverse Action Incident*** business process to remove provider from	DMAS does not receive disenrollment from insurance affordability program.

EE Provider Enrollment		
Disenroll Provider		
Item	**Details**	**DMAS Differences/Comments**
	services. • Receive alert from ***Close Out Contract*** business process to remove provider from services. Environment-based Trigger Events to include but not limited to: • Receive request to disenroll provider. • Receive information from Medicare/Medicaid Sanction, National Practitioner Databank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), or state licensing boards. • Receive information about a provider's death, retirement, or disability.	We do not receive information from NPDB or HIPDB since it is not required due to ACA; capability exists to process if received. DMAS receives automated information regarding death; retirement and disability are manual.
Result	• Agency disenrolls Provider or contractor from participation in Medicaid Program. • Alert sent to notify provider via ***Manage Provider Communication*** business process of disenrollment information. • Alert sent to notify contractor via ***Manage Contractor Communication*** business process of disenrollment. • Alert sent to notify Medicare/Medicaid Sanction, National Practitioner Data Bank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), and state licensing boards via ***Manage Business Relationship Communication*** business process of disenrollment information. • If applicable, alert sent to ***Manage Contractor Payment*** to stop payment arrangement.	Contractors are not disenrolled. Contractors are not disenrolled. Alert is sent to OIG and MCSIS to notify Medicare/Medicaid Sanction; alerts are not sent to NPDB or HIPDB. Contractors are not disenrolled.

EE Provider Enrollment		
Disenroll Provider		
Item	**Details**	**DMAS Differences/Comments**
	• Alert sent to ***Close Out Contract*** business process with disenrollment information. • Alert sent to ***Apply Mass Adjustment*** business process to associate members with alternate provider or contractor. • Alert sent to notify Health Insurance Marketplace of provider disenrollment information. • Tracking information as needed for measuring performance and business activity monitoring.	Contractors are not disenrolled. Alert is not sent to Health Insurance Marketplace.
Business Process Steps	1. **START:** Receive disenrollment request or relevant information. 2. Validate authenticity of the requestor to have authorization to request disenrollment. 3. Determine disenrollment request or information processing status by querying the Provider data store. Application status may be one of the following: initial, resubmitted with modification, or duplicate. a. If resubmitted application, message contains only updated information and process may skip irrelevant steps below. b. If duplicate application, produce result messages and stop business process (see Failures). c. Other communications may be requests to cancel application, and to	

EE Provider Enrollment		
Disenroll Provider		
Item	**Details**	**DMAS Differences/Comments**
	deactivate or reactivate enrollment. 4. Verify the disenrollment information. 5. Validate that the disenrollment request meets state rules. 6. Remove provider or contractor from Medicaid participation. 7. Send alert to notify Medicare/Medicaid Sanction, NPDB, HIPDB, and state licensing boards via ***Manage Business Relationship Communication*** business process of disenrollment information. 8. If applicable, send alert to ***Manage Contractor Payment*** business process to stop payment arrangement. 9. Send alert to ***Close Out Contract*** business process with disenrollment information. 10. Send alert to ***Apply Mass Adjustment*** business process to associate members with alternate provider or contractor. 11. Send alert to notify provider via ***Manage Provider Communication*** business process of disenrollment information. 12. Send alert to notify contractor via ***Manage Contractor Communication*** business process of disenrollment. 13. Send alert to notify other insurance affordability programs of the disenrollment from Medicaid. 14. Send alert to notify Health Insurance Marketplace of provider disenrollment information. 15. **END:** Agency removes Provider or	Contractors are not disenrolled. #13 and #14 are not performed.

EE Provider Enrollment		
Disenroll Provider		
Item	**Details**	**DMAS Differences/Comments**
	contractor from participation in Medicaid services.	
Shared Data	Provider data store including provider network and contact information (e.g., NPI, provider demographics, provider taxonomy) NPI and provider demographics exchanged with National Plan and Provider Enumeration System (NPPES) Provider sanction information such as: a. The Office of Inspector General or the General Accounting Office (OIG/GAO) sanction lists of individuals, vendors, and/or suppliers that are excluded from participation in Medicare, Medicaid, and other federally funded state programs b. State Provider Licensing Authority c. HIPDB d. NPDB Tax identifiers: Employer ID Number (EIN), Social Security Number (SSN), Taxpayer Identification Number (TIN) from applicant and verified with tax identifier verification sources Insurance Affordability Program data store including eligibility and enrollment information	OIG only; not GAO HIPDB and NPDB are not applicable to DMAS DMAS does not share data with the Insurance Affordability Program
Predecessor	***Determine Provider Eligibility*** ***Manage Compliance Incident Information*** ***Manage Provider Information*** ***Manage Contractor Information*** ***Determine Adverse Action Incident*** ***Close Out Contract***	Contractors are not disenrolled. Providers of service sign a Provider Agreement

EE Provider Enrollment		
Disenroll Provider		
Item	**Details**	**DMAS Differences/Comments**
Successor	***Manage Provider Communication*** ***Manage Provider Information*** ***Manage Contractor Communications*** ***Manage Contractor Information*** ***Manage Business Relationship Communication*** ***Manage Contractor Payment*** ***Close Out Contract*** ***Apply Mass Adjustment***	Contractors are not disenrolled. Contractors are not disenrolled. Contractors are not disenrolled. Provider agreements are terminated
Constraints	The Provider disenrollment process will accommodate the full range of provider types, organizations, specialties, different types of applicants (e.g., the Primary Provider, Billing Agent, Pay-To Entity), and care settings (e.g., solo office practice, group practice, Rural Health Clinic) as well as different types of application (e.g., New, Modification, Cancellation, Update). Different business rules will apply to each of these different types.	
Failures	• Duplicate disenrollment requests. • Requirement for additional information to process disenrollment.	Written requests for disenrollment must be on appropriate letterhead.
Performance Measures	• Time to complete Disenrollment process = within ____ days • Accuracy with which edits are applied = ___%	• ≤10 days • 98%

EE Provider Enrollment		
Disenroll Provider		
Item	**Details**	**DMAS Differences/Comments**
	• Consistency of decisions and disposition =___ • Error rate = _____ % or less	• n/a • 0%

3.4.2.3.2 As-Is Assessment

The overall rating for the Disenroll Provider business process is '2.' DMAS processes and performance consistently aligns with the Level 2 capabilities as defined.

Other items noted in the As-Is assessment were:

- DMAS sends alerts to other agencies when providers are disenrolled
- DMAS does not notify other insurance programs or the Health Insurance Marketplace when providers are disenrolled.

3.4.2.3.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Disenroll Provider business process. This includes:

- Fully automating the provider disenrollment process within the intrastate, sharing Provider Network information with the Health Insurance Marketplace (HIX), producing an audit trail of disenrollment 100% of the time
- Adopting standard provider disenrollment interfaces and other nationally recognized provider disenrollment industry standards for intrastate exchange of provider disenrollment information
- Collaborating with other intrastate agencies and entities to adopt national provider disenrollment standards as well as develop and share reusable business services
- Improving timeliness via state and federal collaboration, use of provider disenrollment information sharing, standards, and regional information exchange hubs
- Automating and standardizing business rules definitions for provider disenrollment decision-making
-

3.4.2.3.4 Scorecard

The following scorecard was compiled for the Disenroll Provider business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
EE - Provider Enrollment Disenroll Provider	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.4.2.4 Inquire Provider Eligibility

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Inquire Provider Eligibility business process.

3.4.2.4.1 Business Process Model

The Inquire Provider Eligibility business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

EE Provider Enrollment		
Inquire Provider Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Inquire Provider Information*** business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry, and prepares the response information for the **Send Outbound Transaction**.	This is a public facing portal function. Only providers that are associated with a billed claim within the past 6 months and new providers enrolled within the last 180 days are displayed.
Trigger Event	Interaction based Trigger Events: • Receive eligibility inquiry via Automated Voice Response System (AVRS). Environment-based Trigger Events to include but not limited to: • Receive provider enrollment verification request from **Receive Inbound Transaction**.	This process is not provided via AVRS.
Result	• Provider enrollment verification response that may include information such as enrollment start/end dates, provider type, and specific specialties provided. • If applicable, response sent with eligibility inquiry information via AVRS. • Tracking information as needed for measuring performance and business activity monitoring.	Dates are not displayed AVRS is not supported No tracking information is maintained
	1. **START:** Receive provider	Only steps 1, 4, and 7 apply

EE Provider Enrollment		
Inquire Provider Information		
Item	**Details**	**DMAS Differences/Comments**
Business Process Steps	enrollment verification information from **Receive Inbound Transaction**. 2. Agency logs enrollment verification request. 3. Validate requestor's authorization to receive requested information. 4. Find requested provider's enrollment verification information. 5. Agency logs response. 6. If applicable, send eligibility inquiry response via AVRS. 7. **END:** Send response to requestor via **Send Outbound Transaction**.	Since this is public facing, anyone can use it

Shared Data	Provider data store including:
	
	• Provider demographics
	• Provider network
	• Contract information
	  ○ Type
	  ○ Specialty
	  ○ Enrolled Program
	  ○ Jurisdiction
	  ○ Payment Information
		
		Not displayed
		Not displayed
		Not displayed

EE Provider Enrollment		
Inquire Provider Information		
Item	**Details**	**DMAS Differences/Comments**

	• Provider taxonomy
	• Service Location Information
	  ○ Category of Service
	  ○ Services
	  ○ Limitations
	  ○ Business Arrangement
		Not displayed
		
		Only the service location address is displayed, not category of service, limitations, etc.

Predecessor	**Receive Inbound Transaction**	
Successor	**Send Outbound Transaction**	
Constraints	States determine what information share and who can access what requested information.	Anyone can access via web
Failures	• Process unable to process the provider information verification request. • Unauthorized requester cannot receive requested information.	
Performance Measures	• Time to verify provider information and generate response information: e.g., Real Time Response = within ____ seconds, Batch Response = within _____ hours • Response Accuracy = _____% • Error rate = _____% or less	Real time responses should meet the following: • 50% of transactions complete <=5.0 sec • 80% of transactions complete <=30 sec • 99.9% of transactions complete <=2 min, however this function is not measured.

3.4.2.4.2 As-Is Assessment

The overall rating for the Inquire Provider Eligibility business process is '2.' While a web-based inquiry is available, the amount of information returned is limited.

Other items noted in the As-Is assessment were:

- This inquiry is public facing so can be used by anyone; it is available to members and potential members
- Provider inquiries are not logged.

3.4.2.4.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Inquire Provider Eligibility business process. This includes:

- Fully automating, to the extent possible, the inquire provider information functionality, including logging inquiries
- Adopting provider inquiry standard messages and other nationally recognized provider inquiry standards for intrastate exchange of provider enrollment information
- Collaborating with other intrastate agencies and entities to adopt national provider inquiry standards and share reusable business services
- Improving timeliness via state and federal collaboration, use of provider inquiry information sharing, standards, and regional information exchange hubs
- Automating the collection of provider inquiry information increasing the reliability of DMAS' internal information
- Automating and standardizing business rules definitions for provider inquiry decision-making

3.4.2.4.4 Scorecard

The following scorecard was compiled for the Inquire Provider Eligibility business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
EE - Provider Enrollment Inquire Provider Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3

Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5 FINANCIAL MANAGEMENT

OVERVIEW

The Financial Management business area is a collection of business processes to support the payment of providers, managed care organizations, other agencies, insurers, Medicare premiums, and supports the receipt of payments from other insurers, providers, and member premiums and financial participation. These processes share a common set of payment- and receivables-related data. The Financial Management business area is responsible for the financial data store.

The Financial Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.5-1.

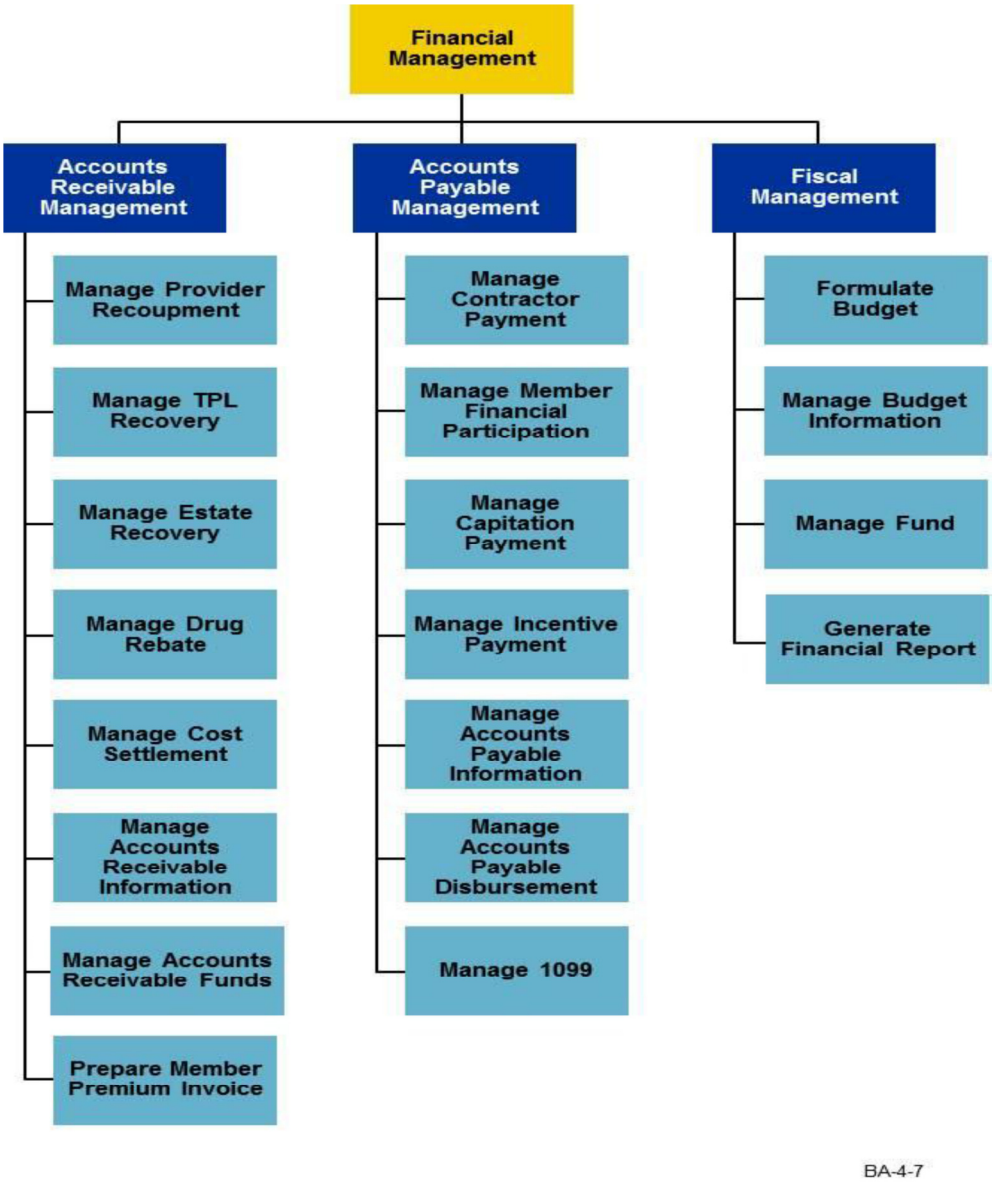


Figure 3.5-1

BUSINESS ARCHITECTURE PROFILE

The Financial Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Financial Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Manage Provider Recoupment		As-Is	To-Be		
Manage TPL Recovery		As-Is	To-Be		
Manage Estate Recovery		As-Is	To-Be		
Manage Drug Rebate			As-Is / To-Be		
Manage Cost Settlement		As-Is	To-Be		
Manage Accounts Receivable Information		As-Is	To-Be		
Manage Accounts Receivable Funds		As-Is	To-Be		
Prepare Member Premium Invoice		As-Is	To-Be		
Manage Contractor Payment			As-Is / To-Be		
Manage Member Financial Participation		As-Is	To-Be		
Manage Capitation Payment			As-Is / To-Be		
Manage Incentive Payment	As-Is NA				
Manage Accounts Payable Information		As-Is	To-Be		
Manage Accounts Payable Disbursement		As-Is	To-Be		
Manage 1099		As-Is	To-Be		
Formulate Budget			As-Is / To-Be		
Manage Budget Information			As-Is / To-Be		
Manage Fund		As-Is	To-Be		
Generate Financial Report		As-Is	To-Be		

3.5.1 Accounts Receivable Management

As shown in Figure 3.5-1, the Accounts Receivable Management business category is made up of eight business processes:

- Manage Provider Recoupment
- Manage TPL Recovery
- Manage Estate Recovery
- Manage Drug Rebate
- Manage Cost Settlement
- Manage Accounts Receivable Management
- Manage Accounts Receivable Funds
- Prepare Member Premium Invoice.

Details regarding the assessment of each Accounts Receivable Management business process follow.

3.5.1.1 Manage Provider Recoupment

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Provider Recoupment business process.

3.5.1.1.1 Business Process Model

The Manage Provider Recoupment business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Receivable Management		
Manage Provider Recoupment		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Provider Recoupment*** business process manages the determination and recovery of overpayments to providers. The State Medicaid Agency (SMA) initiates provider recoupment upon the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where provider owes monies to the SMA due to fraud or abuse. The business thread begins with	The BHSA vendor (Magellan) performs recoupments for behavioral health providers that are no longer active in the VaMMIS system.

FM Accounts Receivable Management		
Manage Provider Recoupment		
Item	**Details**	**DMAS Differences/Comments**
	discovering the overpayment, then retrieving claims payment information, initiating the recoupment request, or adjudicating a claims adjustment request, and notifying the provider of audit results via the ***Manage Provider Communication*** business process, applying recoupments in the system via the ***Manage Accounts Receivable Information*** business process, and monitoring payment history until the provider satisfies the repayment. The SMA collects recoupments via check sent by the provider or credited against future payments for services.	
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Adjustment claim by the ***Process Claim*** or ***Process Encounter*** business processes. Environment-based Trigger Events to include but not limited to: • Periodic Provider utilization review audit by the ***Identify Utilization Anomalies*** business process is due. • Receive adverse action disposition from the ***Determine Adverse Action Incident*** business process. • Periodic post payment audit by the ***Identify Utilization Anomalies*** business process is due.	***Process Encounter*** does not trigger a recoupment.
Result	. • Alert sent to notify provider of recoupment request. • Alert sent to monitor recoupment activities to ***Manage Accounts***	

FM Accounts Receivable Management		
Manage Provider Recoupment		
Item	**Details**	**DMAS Differences/Comments**
	Receivable Information business process. • Alert sent to ***Apply Mass Adjustment*** business process for retroactive modifications. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START**: Discover overpayment as the result of a routine adjustment request, a provider utilization review, fraud and abuse case, or involvement of a third-party payer. 2. Retrieve claims payment information. 3. Initiate recoupment request. 4. Send alert to notify provider of recoupment request (e.g., amount owed). 5. Negotiate agreed upon method of repayment or recoupment. 6. If applicable, send alert to ***Apply Mass Adjustment*** business process for retroactive modifications. 7. **END:** Send alert to monitor recoupment activities to ***Manage Accounts Receivable Information*** business process.	Includes results from HMS and other audit contractors Letters are sent as an alert for recoupments by audits conducted by DMAS and audit contractors, e.g., HMS, Myer & Stauffer. Remittance Advice is 'alert' for claim adjustments. Payment schedules can last up to 36 months

FM Accounts Receivable Management		
Manage Provider Recoupment		
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Claims data store including payment information Provider data store including provider network and contract information Plan data store including policy and fee information Health Benefit data store including benefit program and benefit information Member data store including third-party liability information Financial data store including accounts receivable information Compliance Management data store including compliance incident information	
Predecessor	***Identify Utilization Anomalies*** ***Process Claim*** ***Process Encounter*** ***Determine Adverse Action Incident***	Audit contractor results are used to 'Identify Utilization Anomalies' ***Process Encounter*** is not applicable
Successor	**Send Outbound Transaction** ***Manage Accounts Receivable Information*** ***Manage Provider Communication*** ***Apply Mass Adjustment***	
Constraints	Policies and procedures differ by state. Integration with state accounting system can greatly affect the state's ability to track receivables established by the recoupment.	
Failures	• The SMA is unable to agree on	

FM Accounts Receivable Management		
Manage Provider Recoupment		
Item	**Details**	**DMAS Differences/Comments**
	amount owed or method of recoupment.	
Performance Measures	• Time to complete provider recoupment process: e.g., Real Time response = within _seconds, Batch Response = within _hours • Accuracy with which recoupments are applied =__% • Consistency of decisions on suspended claims/encounters =____% • Error rate =_% or less	Time to establish recoupment based on identification as well as time to recoup funds varies. Goal is to recoup funds within in a year of finding (NPR letter), based on requirement to return federal share. Some may last up to 3 years based on agreement. Accuracy = 96% Consistency of recoupment process: Process consistency varies based on type of recoupment; also varies based on Magellan performing Error rate = 4%

3.5.1.1.2 As-Is Assessment

The overall rating for the Manage Provider Recoupment business process is '2.' DMAS performs this process in a manner that is consistent with the BPM. DMAS contractors, including HMS for TPL, can identify the need for a recoupment.

Other items noted in the As-Is assessment were:

- DMAS does not make payments based on encounters so they do not trigger provider recoupments
- This process is highly automated, though communications is mostly by letter
- HMS is paid a percentage of funds recouped, which ensures cost effectiveness
- Timeliness was recently improved by a system change to a 36 month limit for payment

schedules.

3.5.1.1.3 To-Be Assessment

DMAS intends to move the Manage Provider Recoupment business process to a Level 3.

Specific changes identified include:

- Use more electronic communication where possible when dealing with providers
- Implement a payer-to-payer recoupment process where it is feasible and effective
- Establish information exchanges with other entities that can improve the process
- Identify and capture performance measures and use them to identify additional improvements.

3.5.1.1.4 Scorecard

The following scorecard was compiled for the Manage Provider Recoupment business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Receivables Management Manage Provider Recoupment	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		

Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.1.2 Manage TPL Recovery

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage TPL Recovery business process.

3.5.1.2.1 Business Process Model

The Manage TPL Recovery business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Receivable Management		
Manage TPL Recovery		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage TPL Recovery*** business process begins by receiving Third-Party Liability (TPL) information from various sources such as external and internal information matches, tips, referrals, attorneys, compliance management incident, Medicaid Fraud Control Unit (MFCU), providers, and insurance companies. The business process: • Identifies the provider or TPL carrier, locates recoverable claims. • Creates the coordination of benefits file. • Creates post-payment recovery files.	HMS is the vendor that identifies and performs most health claims TPL recoveries. DMAS performs non-health claim recoveries, such as casualty.

FM Accounts Receivable Management		
Manage TPL Recovery		
Item	**Details**	**DMAS Differences/Comments**
	Sends notification to other payer or provider from the ***Manage Provider Communication*** business process.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive third-party liability information from outside sources via the ***Determine Member Eligibility*** business process. • Receive third-party liability information from internal and external eligibility information matches. State transition-based Trigger Events: • Receive claims payment information from ***Process Claim*** or ***Process Encounter*** business process.	***Process Encounter*** is not a trigger. MCOs perform their own TPL recovery. DMAS performs some casualty recovery for MCO eligible members.
Result	Alert sent to notify third-party liability of recovery request. Alert sent to ***Manage Accounts Receivable Information*** business process to monitor for payment. Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive third-party liability information. 2. Identify the provider or TPL carrier. 3. Locate recoverable claims.	

FM Accounts Receivable Management		
Manage TPL Recovery		
Item	**Details**	**DMAS Differences/Comments**
	4. Create coordination of benefit files. 5. Create post-payment recovery files. 6. Send alert to notify provider or other payer of recovery request. 7. Conduct follow-up necessary and record activities. 8. Send alert to monitor recoupment activities to ***Manage Accounts Receivable Information*** business process. 9. **END:** Close and archive TPL Recovery case file upon conclusion of activities.	HMS either bills the carrier or sends letter notification to provider to bill the insurance company and refund/adjustment to DMAS.
Shared Data	Financial data store including accounts receivable information Member data store including enrollment information Provider data store including provider network and carrier information Health Insurance Marketplace data store Compliance Management data store including compliance incident information Other Agency Information: • Department of Motor Vehicles (DMV) • Veterans Administration (VA) • Indian Health Service	Member data includes coverage information; HMS sends monthly insurance verification information Carrier information is maintained separate from Provider data This is not used by DMAS This is not used by DMAS

FM Accounts Receivable Management		
Manage TPL Recovery		
Item	**Details**	**DMAS Differences/Comments**
	• Immigration and Naturalization Service • Medicaid Fraud Control Unit (MFCU)	Some of these agencies, e.g., DMV and VA, may be used during enrollment by DSS Indian Health Service is not used DMAS uses Department of Child Support and Enforcement (Absent Parent), Medicare, DOD
Predecessor	**Receive Inbound Transaction** ***Determine Adverse Action Incident*** ***Determine Member Eligibility*** ***Process Claim*** ***Process Encounter***	Process encounter does not apply; MCOs perform their own recovery
Successor	**Send Outbound Transaction** ***Manage Provider Communication*** ***Manage Accounts Receivable Information***	
Constraints	States differ in the rules applied to TPL recoveries. Capabilities related to information matches vary and some States utilize recovery	DMAS uses a recovery

FM Accounts Receivable Management		
Manage TPL Recovery		
Item	**Details**	**DMAS Differences/Comments**
	services contractors. The state's integration of eligibility determination systems also has significant impact on their ability to cost avoid versus cost recover.	services contractor.
Failures	• Inability to identify third-party payer from received third-party liability information. • Identified third-party payer denies liability or otherwise refuses to pay.	
Performance Measures	• Time to complete the process = Real Time response = within seconds, Batch Response = within hours • Accuracy with which the TPL rules are applied = % • Consistency with which the TPL rules are applied = % • Amount of dollars recovered =_____% • Error rate (false recovery demands) = % or less	There is no stated time to complete, however vendor payment is based on recoveries 95% 100% N/A N/A

3.5.1.2.2 As-Is Assessment

The overall rating for the Manage TPL Recovery business process is '2.' HMS is the vendor that identifies and performs most health claims TPL recoveries, while DMAS performs non-health claim recoveries, such as casualty. HMS employs a system and procedures that follow industry standards.

Other items noted in the As-Is assessment were:

- HMS is paid a percentage of funds recouped, which ensures cost effectiveness and is an incentive to complete the process as soon as possible

- DMAS processes are more manual, but the system is used for research
- There is interaction with other agencies and entities, such as the Department of Child Support and Enforcement
- HMS maintains 95% accuracy based on claims identified that have liability.

3.5.1.2.3 To-Be Assessment

DMAS intends to move the Manage TPL Recovery business process to a Level 3.

Specific changes identified include:

- Implement a payer-to-payer Coordination of Benefits process
- Establish information exchanges with other entities that can provide TPL information, including the Health Information Exchange
- Utilize electronic communications with members and providers to the extent possible
- Identify and capture performance measures and use them to identify additional improvements.

3.5.1.2.4 Scorecard

The following scorecard was compiled for the Manage TPL Recovery business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Receivable Management Manage TPL Recovery	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	3
Performance Measure		
Supporting Evidence Reference		

Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.1.3 Manage Estate Recovery

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Estate Recovery business process.

3.5.1.3.1 Business Process Model

The Manage Estate Recovery business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Receivable Management		
Manage Estate Recovery		
Item	**Details**	**DMAS Differences/Comments**
Description	***Manage Estate Recovery*** is a business process that requires States to recover certain Medicaid benefits correctly paid on behalf of an individual, by filing liens against a deceased member's or deceased spouse's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), or other medical institution.	DMAS files claims and not liens. Where process says lien, we substitute claim.

FM Accounts Receivable Management		
Manage Estate Recovery		
Item	**Details**	**DMAS Differences/Comments**
	The ***Manage Estate Recovery*** business process begins by receiving estate recovery information from multiple sources (e.g., vital statistics and Social Security Administration (SSA) date of death matches, probate petition notices, tips from caseworkers, and reports of death from nursing homes). It generates correspondence (e.g., demand of notice to probate court via **Send Outbound Transaction**, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the ***Manage Applicant and Member Communication*** business process. In addition, the business process: • Opens a formal estate recovery case based on estate ownership and value of property. • Determines the value of the estate lien. • Files a petition for a lien. • Files an estate claim of lien. • Conducts case follow-up. • Sends an alert to ***Manage Accounts Receivable Information*** business process, releasing the estate lien when recovery is complete. • Sends an alert to ***Manage Member Information*** business process, updating Member data store.	

FM Accounts Receivable Management		
Manage Estate Recovery		
Item	**Details**	**DMAS Differences/Comments**
	NOTE: Do not confuse this with settlements that are recoveries for certain Medicaid benefits correctly paid on behalf of an individual because of a legal ruling or award involving accidents.	
Trigger Event	Environment-transition Trigger Events: • Receive estate recovery information* from mail, publication, telephone, facsimile or Electronic Data Interchange (EDI). • Receive member or provider death certificates. * Many States have Medicaid Estate Recovery Plans used to recover an equitable amount of the state and federal shares of the cost paid for the member from the estates of members of medical assistance.	No death certificates are used in the process but death information is used from members and/or providers. Virginia Department of Health (VDH) provides notice of death DMAS may receive notice of member death from providers, e.g., nursing homes
Result	• Estate recovery case file closed upon Receive maximum possible payment. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive estate recovery referral information via several different sources (e.g., vital statistics and Social Security Administration (SSA) date of death match, probate petition notices, eligibility caseworker, and nursing homes). 2. Send demand notice information to member correspondence (e.g., onto probate court). 3. Send alert to notify deceased representative to complete estate recovery questionnaire.	New Estate information request letter implemented for Release 66. Estate information request

FM Accounts Receivable Management		
Manage Estate Recovery		
Item	**Details**	**DMAS Differences/Comments**
	4. Open estate recovery case. 5. Determine value of estate lien by analyzing all Medicaid claims from age 55 forward (e.g., all paid claims equals lien amount). 6. If applicable, member may file an undue hardship waiver based on state regulations. If the State Medicaid Agency (SMA) grants hardship, staff defers or closes the case. 7. Generate estate recovery proceedings information (e.g., lien petition, notice of pendency of action) and send via **Send Outbound Transaction**. 8. Upon court approval, file estate claim of lien. 9. Case follow-up occurs (every 30 to 90 days). 10. Send alert to monitor recovery activities to ***Manage Accounts Receivable Information*** business process. 11. If applicable, send alert to ***Manage Member Information*** business process, updating Member data store. 12. **END:** Closed and archive estate recovery case file upon conclusion of activities.	letter Lien = 'claim' Court approval is not needed to file a claim Follow-up is every 90 days
Shared Data	Financial data store including accounts receivable information Member data store including demographics Claims data store including payment information	

FM Accounts Receivable Management		
Manage Estate Recovery		
Item	**Details**	**DMAS Differences/Comments**
	Vital Statistic records SSA records Centers for Medicare & Medicaid Services (CMS) Medicare/Medicaid Dual Eligibility reporting Health Insurance Marketplace data store Judicial records	Department of Health Not used Not used
Predecessor	**Receive Inbound Transaction**	
Successor	**Send Outbound Transaction** ***Manage Applicant and Member Communication*** ***Manage Accounts Receivable Information*** ***Submit Electronic Attachment***	Submit Electronic Attachment process not associated with this in Virginia.
Constraints	The ***Manage Estate Recovery*** business process will be in accordance with state specific policy.	
Failures	• The SMA or member's representative is unable to meet filing timelines.	

FM Accounts Receivable Management		
Manage Estate Recovery		
Item	**Details**	**DMAS Differences/Comments**
Performance Measures	• Time to complete the process = e.g., ___months,weeks or_____days • Accuracy with which rules are applied = % • Consistency with which rules are applied = % • Error rate = % or less • Amount of dollars recovered =_____%	1 year, but can go longer 100% accuracy 100% consistency 0% error rate N/A for amount recovered, can only recover based on size of estate

3.5.1.3.2 As-Is Assessment

The overall rating for the Manage Estate Recovery business process is '2.' DMAS employs a combination of manual and automated processes, however communication with stakeholders is primarily electronic. Internal standards are consistently used.

Other items noted in the As-Is assessment were:

- Recoveries are generally completed within 12 months but can take longer
- The accuracy of the data and results is considered to be 100%.

3.5.1.3.3 To-Be Assessment

DMAS will investigate the cost-effectiveness of moving the Manage Estate Recovery business process to a Level 3.

Specific changes identified to be further considered include:

- Implement additional automation in the process
- Utilize electronic communications with stakeholders
- Collaboration with other entities, including information exchanges
- Identify and capture performance measures and use them to identify additional improvements.

3.5.1.3.4 Scorecard

The following scorecard was compiled for the Manage Estate Recovery business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Receivable Management Manage Estate Recovery	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	1	2
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.1.4 Manage Drug Rebate

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Drug Recovery business process.

3.5.1.4.1 Business Process Model

The Manage Drug Recovery business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Receivable Management		
Manage Drug Rebate		
Item	***Details***	***DMAS Differences/Comments***
Description	The ***Manage Drug Rebate*** business process describes the process of managing drug rebate that the State Medicaid Agency (SMA) collects from manufacturers. This business process: Receives quarterly drug rebate information from Centers for Medicare & Medicaid Services (CMS). Compares drug rebate to quarterly payment history information. Identifies drug information matches based on manufacturer and drug code. Applies the rebate factor and volume indicators. Calculates the total rebate per manufacturer. Prepares drug rebate invoices. Sorts the invoices by manufacturer and drug code. Sends the invoice information to the drug manufacturer via the **Send Outbound Transaction**. Sends an alert to ***Manage Accounts Receivable Information*** to monitor for rebate payment.	This process is performed primarily by a vendor (Catamaran). It includes fee-for-service, managed care, and supplemental rebates. Each group is sent in a separate invoice. Each group is considered a client and therefore the manufacturers receive a separate invoice for each. Magellan provides supplemental drug rebate information Create invoice by 'type' i.e., claims, encounters, and supplemental; also creates totals by drug code Invoices sent within 60 days of end of federal fiscal year quarter; sent via paper and electronically, per CMS standards Catamaran maintains the A/R

FM Accounts Receivable Management		
Manage Drug Rebate		
Item	***Details***	***DMAS Differences/Comments***
		information
Trigger Event	Interaction-based Trigger Event: • Receive the CMS quarterly drug rebate information from **Receive Inbound Transaction.**	
Result	• Alert sent to invoice the drug manufacturer. • Alert sent to **Manage Accounts Receivable Information** business process to monitor for payment. • Tracking information as needed for measuring performance and business activity monitoring.	The invoices (paper and electronic) are sent by Catamaran as part of the ***Manage Drug Rebate*** process
Business Process Steps	1. **START:** The state receives a quarterly file from CMS containing the rebate factors by manufacturer, drug code, and volume. 2. Compare file to the corresponding claims history extract for the same quarter. 3. Select drug claims matching the manufacturer and drug codes based on the CMS Drug Product Data. 4. Sort drug claims selected for invoice processing by manufacturer and drug code. 5. Apply the rebate factor and volume indicators to calculate a rebate total per manufacturer. 6. Send alert to invoice manufacturer.	State gives Catamaran the rights to download the CMS quarterly file and Catamaran compares and sorts the drug claims for invoice processing. Catamaran sends the invoice and establishes the accounts receivable entries. There are separate invoices for fee-for-service rebates, managed care rebates, and supplemental rebates.

FM Accounts Receivable Management		
Manage Drug Rebate		
Item	***Details***	***DMAS Differences/Comments***
	7. **END:** Send alert to monitor payment activities to ***Manage Accounts Receivable Information*** business process.	
Shared Data	CMS Unit Rebate Amount (URA) information Claims data store including both professional and drug payment information Reference data store including drug code and manufacturer information Financial data store including accounts receivable information	Magellan supplies supplemental URA information for supplemental rebates. Medicaid and FAMIS claims and encounters The CMS DDR (Drug Data Report) is an information source; Catamaran and VAMMIS access this Catamaran maintains the accounts receivable information
Predecessor	**Receive Inbound Transaction**	
Successor	**Send Outbound Transaction** ***Manage Contractor Communication*** ***Manage Accounts Receivable Information***	Regular communications with contractor as needed to review drug disputes, e.g., units, and other topics including impacts of CMS requirements
Constraints	The ***Manage Drug Rebate*** business process will be in accordance with state- specific drug formulary, business rules, and reporting requirements that may differ by state, and will comply with federal mandates.	
Failures	CMS does not send quarterly drug rebate information. There are no drug claims for rebate	Manufacturers have provided URA information when CMS could not make it available

FM Accounts Receivable Management		
Manage Drug Rebate		
Item	***Details***	***DMAS Differences/Comments***
	matching the manufacturer and drug codes based on the CMS Drug Product Data for the period. **NOTE**: the process could complete with errors (e.g., errors in rebate rates, drug payment file errors), and the SMA would correct these errors or disputed amounts in the ***Manage Accounts Receivable Information*** business process.	Claims adjudication ensures drug codes are valid and rebatable
Performance Measures	• Time to complete the process = e.g., ___months,weeks or_____days • Accuracy with which the Drug Rebate rules are applied = % • Consistency with which the Drug Rebate rules are applied = % • Amount of drug rebate dollars recovered quarterly =_____% • Error rate = % or less	Invoices sent within 60 days, including supplemental invoices 100% but no DMAS activity to validate 100% but no DMAS activity to validate No defined expectation, but usually > 98%, however this can drop on an exception basis Expectation is 0%, but some problems do occur ---------- Catamaran consistently performs well

3.5.1.4.2 As-Is Assessment

The overall rating for the Manage Drug Recovery business process is '3.' DMAS uses a vendor to perform this process, with DMAS oversight. The vendor's system is a nationally recognized product that provides DMAS efficiency and cost-effectiveness. It automates the process to a high-level through a reusable business service.

Other items noted in the As-Is assessment were:

- Recoveries are generally completed within 60 days of the end of the federal fiscal year quarter
- The accuracy of the data and results is considered to be 100%
- 98% of identified drug rebates are recovered, which is substantiated through invoicing and reporting.

3.5.1.4.3 To-Be Assessment

DMAS is generally pleased with the current level of performance of the Manage Drug Recovery business process. We will likely continue to use a vendor to perform the process in an efficient, effective, and timely manner.

To improve timeliness, we will explore additional electronic information sharing and posting invoices on Web portals.

3.5.1.4.4 Scorecard

The following scorecard was compiled for the Manage Drug Recovery business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM – Accounts Receivable Management Manage Drug Rebate	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	3	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	3

Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	3	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		
Supporting Evidence Reference		

3.5.1.5 Manage Cost Settlement

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Cost Settlement business process.

3.5.1.5.1 Business Process Model

The Manage Cost Settlement business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Receivable Management		
Manage Cost Settlement		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Cost Settlement*** business process begins with the submission of the provider's annual Medicare Cost Report to Medicaid. Staff makes inquires for paid, denied, and adjusted claims information in the Claims data store. The business process includes: • Reviewing provider costs and establishing a basis for cost settlements or compliance reviews. • Receiving audited Medicare Cost Report from intermediaries.	This process is performed outside the MMIS. The cost settlement cost reports are produced in Oracle.

FM Accounts Receivable Management		
Manage Cost Settlement		
Item	**Details**	**DMAS Differences/Comments**
	• Capturing the necessary provider cost settlement information. • Calculating the final annual cost settlement based on the Medicare Cost Report. • Generating the information for notification to the provider. • Verifying the information is correct. • Producing the notifications to providers. • Establishing interim reimbursement rates. **NOTE:** In some States, the State Medicaid Agency (SMA) may make cost settlements through the ***Apply Mass Adjustment*** business process.	Myers & Stauffer, a cost settlement and audit contractor, performs the cost settlement process for DMAS. The process begins with the receipt of the Medicaid and As-Filed Medicare Cost Reports. A MARS report from the MMIS contains the needed claims data for cost settlement. Audited Medicare Cost Reports are no longer provided by the intermediaries. In some cases, no reimbursement is generated at settlement. The cost reports are used to establish reimbursement rates using the methodologies defined in the State Plan. DMAS is working toward converting cost-based reimbursement to

FM Accounts Receivable Management		
Manage Cost Settlement		
Item	**Details**	**DMAS Differences/Comments**
		prospective reimbursement.
Trigger Event	Environment-based Trigger Event: • Receive provider costs from claims history data store. • Receive Medicare Cost Report. • Prompt for annual provider cost review.	The source for charge data is MARS which is used to generate costs from information (cost to charge ratio) provided in the Medicare Cost Report.
Result	• Alert sent to notify provider of cost settlement information. • Alert sent to ***Manage Accounts Receivable Information*** business process to monitor for payment. • Alert sent to ***Manage Rate Setting*** business process of interim reimbursement rates. • Tracking information as needed for measuring performance and business activity monitoring.	In some cases, no reimbursement is generated at settlement There is a cost report tracking system in Oracle. This tracks receipt, review, and settlement.
Business Process Steps	1. **START:** Receive Medicare Cost Report from provider. 2. Request annual claims detail information. 3. Review provider costs. 4. Establish a basis for cost settlements or compliance reviews.	#1. A notification is sent to a provider that the MARS Claims Summary Information Report is available by posting a URL using GoFileRoom for NF and ICF; others

FM Accounts Receivable Management		
Manage Cost Settlement		
Item	**Details**	**DMAS Differences/Comments**
	5. Receive audited Medicare Cost Report from intermediaries from **Receive Inbound Transaction.** 6. Receive provider cost settlement information from **Receive Inbound Transaction**. 7. Capture the necessary provider cost settlement information. 8. Calculate the final annual cost settlement based on the Medicare Cost Report and prorate for Medicaid services. 9. Establish interim reimbursement rates. 10. Generate cost settlement information identifying the amount of overpayment or underpayment and the reimbursement rates the SMA would consider for the next year. 11. Verify the information is correct. 12. Send alert to notify providers of cost settlements summary information. 13. Send cost settlement summary information to providers via **Send Outbound Transaction**. 14. Send alert to monitor payment activities to ***Manage Accounts Receivable Information*** (if overpayment) or to ***Manage Accounts Payable Information*** (if underpayment) business processes. 15. Send alert to conduct retroactive modifications to ***Apply Mass Adjustment*** business process. 16. **END:** Send alert of interim reimbursement rates to ***Manage Rate Setting*** business process.	access reports through the Medicaid portal. The process begins when providers access both the MARS and Medicaid Cost Reports for submission. (The Medicaid Cost Report generated using Oracle. We do not use the CMS module for the Medicaid Cost Report.) #1 includes receiving the Medicare and Medicaid Cost Report from the provider using GoFileRoom for NF and ICF; others send via e-mail or mail. #2. The Medicaid claims detail is available through the weekly remittances, if needed. #4. Also includes information used in methodologies for establishing reimbursement. #5 is not applicable #6 Provider cost

FM Accounts Receivable Management		
Manage Cost Settlement		
Item	**Details**	**DMAS Differences/Comments**
		settlement information comes from MARS; see step #1 #7 This is described in #1 #10 A payment (over or under) is not always applicable #12, 13 Accomplished using GoFileRoom for NF and ICF; others receive hard copy reports via mail #15 DMAS does not adjust claims; adjustments are made at the provider level
Shared Data	Claims data store including payment information Provider data store including provider network and contract information Financial data store including accounts receivable information Cost log information sent to Centers for Medicare & Medicaid Services (CMS)	Some claims data produced via MARS or Financial subsystems Provider data store not used for provider network and contract information (but is used for contact and other information) Inflation, case mix, and RS Means come from other sources and are stored in Oracle Cost log information is not sent to Centers for Medicare & Medicaid Services (CMS)

FM Accounts Receivable Management		
Manage Cost Settlement		
Item	**Details**	**DMAS Differences/Comments**
Predecessor	**Receive Inbound Transaction**	
Successor	**Send Outbound Transaction** ***Manage Provider Communication*** ***Manage Accounts Receivable Information*** ***Manage Rate Setting*** ***Apply Mass Adjustment***	DMAS does not use Apply Mass Adjustment
Constraints	Cost Settlement information will conform to CMS and state-specific reporting requirements.	Complete claim and report information; missing data delays the process
Failures	• This process has no failure modes that prevent the process from completion. • Delays are the result of delays in the audited Medicare Cost Report. • A provider may file a grievance if it does not agree with established rates or settlement amounts.	DMAS does not rely on the audited Medicare Cost Report We use the term appeal rather than grievance
Performance Measures	• Time to complete the process = e.g.,___months,weeks or _____days • Accuracy with which the SMA applies Cost Settlement rules = % • Consistency with which the SMA applies Cost Settlement rules = % • Number of grievances or protests received = ___ • Error rate = % or less	180 days to complete after receipt of complete, acceptable information 100% accuracy 100% consistency About 25% result in appeals (an appeal delays any collection

FM Accounts Receivable Management		
Manage Cost Settlement		
Item	Details	DMAS Differences/Comments
		due to program) 0% error rate

3.5.1.5.2 As-Is Assessment

The overall rating for the Manage Cost Settlement business process is '2.' The related processes are well-defined and efficient, and results are accurate. DMAS uses a vendor to perform the process and utilizes automation for added improvements and efficiency.

Other items noted in the As-Is assessment were:

- The processes are automated to the full extent possible
- Use of Oracle for tracking and internet for data exchange increases efficiency
- Automation improves the accuracy; the accuracy of the data and results is considered to be 100%.

3.5.1.5.3 To-Be Assessment

DMAS intends to improve the Manage Cost Settlement business process to a Level 3.

Specific changes identified to be further considered include:

- Implement additional automation in the process, especially information collection
- Utilize electronic communications with stakeholders
- Collaboration with other entities
- Improve timeliness, although attaining 10 days or less may not be feasible
- Identify and capture performance measures and use them to identify additional improvements.

3.5.1.5.4 Scorecard

The following scorecard was compiled for the Manage Cost Settlement business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM – Accounts Receivable Management Manage Cost Settlement	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***

Overall Assessment Level	2	3
Timeliness of Process	2	2
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	3	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.1.6 Manage Accounts Receivable Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Accounts Receivable Information business process.

3.5.1.6.1 Business Process Model

The Manage Accounts Receivable Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Receivable Management		
Manage Accounts Receivable Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Accounts Receivable Information*** business process is responsible for all operational aspects of collecting money owed to the State Medicaid Agency (SMA). Activities in this business process comply with CFR 45, Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP). • Activities included in this business process can be as follows: • Periodic reconciliations between the State Medicaid Enterprise and the state accounting system. • Assign account coding to transactions processed in State Medicaid Enterprise. • Process accounts receivable invoicing (estate recovery, co-pay, drug rebate, recoupment, Third-Party Liability (TPL) recovery, and member premiums). • Manage cash receipting process. • Manage payment-offset process to collect receivables. • Respond to inquiries concerning accounts receivable. **NOTE:** States use a variety of solutions including outsourcing to another department or	

FM Accounts Receivable Management		
Manage Accounts Receivable Information		
Item	**Details**	**DMAS Differences/Comments**
	use of a Commercial Off-the-Shelf (COTS) package.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive initial invoice from ***Manage Provider Recoupment, Manage TPL Recovery, Manage Estate Recovery, Manage Drug Rebate,*** or ***Manage Cost Settlement*** business processes. • Receive account receivable information from state accounting system. This may be a lien, levy or state judgment from other agencies.	
Result	. • The SMA modifies account receivables information. • Alert sent to collect payment to ***Manage Accounts Receivable Funds*** business process. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START**: Receive initial Accounts Receivable invoice to establish the receivable amount and demographic information for the debt owner. 2. Record Accounts Receivable payments to the account balance. 3. Adjust balance for additional Accounts Receivable amounts. An adjustment may increase or decrease the balance. a. The adjustments include settlements, liens, levies, and/or judgments against the Accounts Receivable. b. The SMA may receive the adjustment from ***Manage Provider***	

FM Accounts Receivable Management		
Manage Accounts Receivable Information		
Item	**Details**	**DMAS Differences/Comments**
	Recoupment, Manage TPL Recovery, Manage Estate Recovery, Manage Drug Rebate, or ***Manage Cost Settlement*** business processes or other state or federal agencies. 4. Produce month-end accounts receivable balance and statement. This includes invoices to the debt owner and summary information for financial reports. 5. Update the state accounting system. 6. Send alert to collect payment to *Manage Accounts Receivable Funds* business process. 7. **END**: Send response to requested function.	
Shared Data	Financial data store including accounts receivable information Claims data store including premium and payment information Contractor data store including contract information Member data store including demographics, spend-down, cost share, and patient liability information Provider data store including provider network information State accounting system accounts receivable information	Member data associated with HIPP payments.
Predecessor	***Receive Inbound Transaction*** ***Manage Cost Settlement*** ***Manage Drug Rebate*** ***Manage TPL Recovery***	Drug Rebate receivables are generated by Catamaran and are invoiced to Drug manufacturers. HIPP receivables are based on

FM Accounts Receivable Management		
Manage Accounts Receivable Information		
Item	**Details**	**DMAS Differences/Comments**
	Manage Estate Recovery ***Manage Provider Recoupment*** ***Prepare Member Premium Invoice***	approved cost evaluated premiums paid by SMA member's authorized representative. Medicare Premium receivables are based on the Buy-in Invoice submitted to SMA by CMS.
Successor	**Send Outbound Transaction** ***Manage Accounts Receivable Information*** ***Generate Financial Report*** ***Manage Data***	
Constraints	The SMA will conform to state-specific accounting and financial requirements.	
Failures	• Failure to account for expenditures in accordance with GAAP can result in disallowance of Federal Funding Participation (FFP).	
Performance Measures	• Time to complete the process = within hours • Accuracy with which updates are applied = 96 % • Consistency with which updates are applied = 100 % • Error rate = 4 %	Time to complete this business process is N/A based on a wide variety of receivable processes involved. 96% accuracy 100% consistency 4% error rate

3.5.1.6.2 As-Is Assessment

The overall rating for the Manage Accounts Receivable Information business process is '2.' DMAS performs this process consistent with the steps defined in the BPM. There is an interface with the state accounting system (CARS) via Oracle Financials, and the process is automated to the extent possible.

Other items noted in the As-Is assessment were:

- Recoveries are generally completed within 60 days of the end of the federal fiscal year quarter
- The data accuracy is considered to be 100%
- 98% of identified drug rebates are recovered, which is substantiated through invoicing and reporting.

3.5.1.6.3 To-Be Assessment

DMAS intends to improve the Manage Accounts Receivable Information business process to a Level 3.

Specific changes identified include:

- Implement additional automation in the process by leveraging current or through new accounting software
- Utilize electronic communications with stakeholders
- Collaboration and electronic information sharing with other entities
- Identify and capture performance measures and use them to identify additional improvements.

3.5.1.6.4 Scorecard

The following scorecard was compiled for the Manage Accounts Receivable Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payables Management Manage Accounts Receivable Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3

Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.1.7 Manage Accounts Receivable Funds

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Accounts Receivable Funds business process.

3.5.1.7.1 Business Process Model

The Manage Accounts Receivable Funds business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Receivable Management		
Manage Accounts Receivable Funds		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Accounts Receivable Funds*** business process is responsible for all operations aspects of the collection of payment owed to the State Medicaid Agency (SMA). Activities in this business process comply with Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles	

FM Accounts Receivable Management		
Manage Accounts Receivable Funds		
Item	**Details**	**DMAS Differences/Comments**
	(GAAP).	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive payment (e.g., cash, check, and credit/debit card). Interaction-based Trigger Events to include but not limited to: • Receive electronic payment (e.g., electronic funds transfer). • Receive periodic scheduled electronic payments.	
Result	• The State Medicaid Agency (SMA) receives payment and applies to accounts receivable. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive payment (e.g., cash, check, credit/debit card, electronic funds transfer). 2. Record the payer and payment amount information. 3. Create payment receipt notice. 4. Notify payer of payment receipt (e.g., email, mail, electronic funds transfer). 5. **END:** Apply payment to accounts receivable.	
Shared Data	Financial data store including accounts receivable information Claims data store including premium information Contractor data store including contract	

FM Accounts Receivable Management		
Manage Accounts Receivable Funds		
Item	**Details**	**DMAS Differences/Comments**
	information Member data store including demographics, spend-down, cost share, and patient liability information Provider data store including provider network information	
Predecessor	**Receive Inbound Transaction** ***Manage Accounts Receivable Information***	
Successor	**Send Outbound Transaction** ***Manage Contractor Communication*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication***	
Constraints	States may have different payment business rules. .	
Failures	• Inability or failure to load initial records or update information in existing records in the Financial data store. • The SMA received no payments.	
Performance Measures	• Time to complete the process = within hours, ____ minutes • Accuracy with which updates are applied = 100 % • Consistency with which updates are applied = 100 % • Error rate = 0 %	SMA uses Net-30 process to apply payments to receivables set up by SMA.

3.5.1.7.2 As-Is Assessment

The overall rating for the Manage Accounts Receivable Funds business process is '2.' However the process is highly automated with use of the Oracle Financials accounting system. Oracle Financials provides easy data access and incorporates industry standards.

Other items noted in the As-Is assessment were:

- DMAS uses Net-30 process to apply payments to receivables it establishes
- The accuracy of the data and results is considered to be 100%
- DMAS consistently employs generally accepted accounting principles (GAAP).

3.5.1.7.3 To-Be Assessment

DMAS intends to improve the Manage Accounts Receivable Funds business process to a Level 3.

Specific changes identified include:

- Implement additional automation in the process by leveraging current or through new accounting software
- Utilize electronic communications with stakeholders
- Collaboration and electronic information sharing with other entities
- Identify and capture performance measures and use them to identify additional improvements.

3.5.1.7.4 Scorecard

The following scorecard was compiled for the Manage Accounts Receivable Funds business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payables Management Manage Accounts Receivable Funds	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		

Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.1.8 Prepare Member Premium Invoice

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Prepare Member Premium Invoice business process.

3.5.1.8.1 Business Process Model

The Prepare Member Premium Invoice business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Receivable Management		
Prepare Member Premium Invoice		
Item	**Details**	**DMAS Differences/Comments**
Description	States may implement member cost sharing through the collection of premiums for medical coverage provided under Medicaid and Children's Health Insurance Program (CHIP). The State Medicaid Agency (SMA) formulates	No notification is sent out to

FM Accounts Receivable Management		
Prepare Member Premium Invoice		
Item	**Details**	**DMAS Differences/Comments**
	the premium amounts on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment. The ***Prepare Member Premium Invoice*** business process begins with a timetable (usually monthly) for scheduled invoicing. The business process includes: • Retrieving member premium information. • Performing required information manipulation according to business rules. • Formatting the results into required output information. • Sending member premium invoice alert to the ***Manage Applicant and Member Communication*** business process. **NOTE:** This business process does not include sending the member premium invoice Electronic Data Interchange (EDI) transaction.	members.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., monthly) is due for scheduled invoicing. • Periodic timetable (e.g., monthly) is due for scheduled health insurance premiums invoicing. State transition-based Trigger Events:	

FM Accounts Receivable Management		
Prepare Member Premium Invoice		
Item	**Details**	**DMAS Differences/Comments**
	• Periodic timetable (e.g., monthly) is due for insurance premium eligibility redetermination and payments.	
Result	• Alert sent to ***Manage Applicant and Member Communication*** business process to send invoice. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Periodic timetable is due for scheduled invoicing. 2. Retrieve member premium information. 3. Adjust member premium information based on state criteria. 4. Format the results into required output information. 5. Produce member invoice information. 6. **END:** Send alert to generate invoice via ***Manage Applicant and Member Communication*** business process.	DMAS performs a cost evaluation to compare premiums to projected cost of services
Shared Data	Financial data store including accounts receivable information Claims data store including premium information Member data store including demographics, cost share, and premium information	Claims data store not used Member data store used for demographics Financials data store used for receivables
Predecessor	***Manage Accounts Receivable Information***	
Successor	***Manage Applicant and Member Communication*** ***Manage Accounts Receivable Information***	

FM Accounts Receivable Management		
Prepare Member Premium Invoice		
Item	**Details**	**DMAS Differences/Comments**
	Manage Accounts Receivable Funds	
Constraints	The ***Prepare Member Premium Invoice*** business process will conform to the state-specific requirements. .	
Failures	• Member premium information not available.	
Performance Measures	• Time to complete process: e.g., Real Time response = within seconds, Batch Responses = within 30 days • Accuracy of decisions = 100 % • Consistency of decisions and disposition = 90 % • Error rate = 0%	No Real Time response done for VA 30 days from the initial member application and DMAS verification (DMAS does not initiate)

3.5.1.8.2 As-Is Assessment

The overall rating for the Prepare Member Premium Invoice business process is '2.' This process is used for the DMAS Health Insurance Premium Payment (HIPP) program. DMAS uses a mix of automated and manual processes that align with the BPM business process steps.

Other items noted in the As-Is assessment were:

- Based on extreme manual processes, data accuracy and consistency of data is low
- The accuracy of the process results is considered to be 100%
- There is very little collaboration with other agencies.

3.5.1.8.3 To-Be Assessment

DMAS intends to look for ways to move the Prepare Member Premium Invoice business process to a Level 3. However, the cost-effectiveness of changes will need to be evaluated given the limited number of premiums paid.

Specific changes identified include:

- Implement additional automation in the process
- Integrate the process into existing available software or business services
- Collaboration and electronic information sharing with other entities
- Identify and capture performance measures and use them to identify additional improvements.

3.5.1.8.4 Scorecard

The following scorecard was compiled for the Prepare Member Premium Invoice business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Receivable Management Prepare Member Premium Invoice	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	1	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		

Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.2 Accounts Payable Management

As shown in Figure 3.5-1, the Accounts Payable Management business category is made up of seven business processes:

- Manage Contractor Payment
- Manage Member Financial Participation
- Manage Capitation Payment
- Manage Incentive Payment
- Manage Accounts Payable Information
- Manage Accounts Payable Disbursement
- Manage 1099.

Details regarding the assessment of each Accounts Payable Management business process follow.

3.5.2.1 Manage Contractor Payment

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Contractor Payment business process.

3.5.2.1.1 Business Process Model

The Manage Contractor Payment business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Payable Management		
Manage Contractor Payment		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Contractor Payment*** business process includes the activities necessary to reimburse contractors for services rendered based on a contract executed between the State Medicaid Agency (SMA) and the	

FM Accounts Payable Management		
Manage Contractor Payment		
Item	**Details**	**DMAS Differences/Comments**
	contractor. When a contractor renders services on behalf of a Medicaid member, the contractor invoices Medicaid according to the specifics defined in the contract. Agency staff responsible for Contract Administration process invoices according to the SMA policy including validation of the invoice content to reimbursement details defined in the contract.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive invoice from contractor (e.g., email, mail, facsimile). Interaction-based Trigger Events to include but not limited to: • Receive electronic invoice from contractor (e.g., Electronic Data Interchange (EDI)).	
Result	• Alert sent to ***Manage Accounts Payable Information*** business process to generate contractor payment. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive invoice from contractor. 2. Validate invoice details for reimbursement details defined in the contract. 3. Resolve any invoicing discrepancies discovered with contractor. 4. **END:** Send alert to ***Manage Accounts Payable Information*** business process to generate contractor payment.	

FM Accounts Payable Management		
Manage Contractor Payment		
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Financial data store including accounts payable information and Recovery Audit Contractor (RAC) recovery information Contractor data store including contract information Member data store including eligibility and benefits information Provider data store including provider network & contract information	
Predecessor	**Receive Inbound Transaction** *Prepare Provider Payment*	
Successor	***Manage Accounts Payable Information***	
Constraints	The ***Manage Contractor Payment*** business process will adhere to the federal and state policies and business rules that may differ by state.	
Failures	• Invoice does not match existing contractor information.	
Performance Measures	• Time to complete the process: e.g., Real Time response = within___ seconds, Batch Response = within hours • Accuracy with which rules are applied =100_____ • Error rate =__0_% or less	PMPM payments for MCOs' Logisticare and other related entities are required to be paid on 1st payment date each month. PPL is required to be paid within 10 days of Invoice being presented to SMA.

3.5.2.1.2 As-Is Assessment

The overall rating for the Manage Contractor Payment business process is '3.' DMAS adheres to the process as described in the BPM and payments are accurate and on time.

Other items noted in the As-Is assessment were:

- Checks are produced through the MMIS by entering financial transactions
- Many interstate and intrastate entities are associated with the process, including the IRS, banks and contractors with NPIs, which adds to the efficiencies of the process.

3.5.2.1.3 To-Be Assessment

DMAS intends to look for ways to improve the Manage Contractor Payment business process within its overall Level 3 rating.

Specific changes identified include:

- Implement additional automation in the process
- Use increased collaboration and electronic information sharing to improve timeliness
- Identify and capture performance measures and use them to identify additional improvements.

3.5.2.1.4 Scorecard

The following scorecard was compiled for the Manage Contractor Payment business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payables Management Manage Contractor Payment	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	3	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	3
Performance Measure		
Supporting Evidence Reference		

Effort to Perform; Efficiency	3	4
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	4
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		
Supporting Evidence Reference		

3.5.2.2 Manage Member Financial Participation

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Member Financial Participation business process.

3.5.2.2.1 Business Process Model

The Manage Member Financial Participation business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Payable Management		
Manage Member Financial Participation		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Member Financial Participation*** business process is responsible for all operations aspects of preparing member premium payments. This includes premiums for Medicare, also known as Medicare Buy-in, and other health insurance. The business process begins with the alert to determine if the State Medicaid Agency (SMA) should pay a member's premium. The SMA will assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as	

FM Accounts Payable Management		
Manage Member Financial Participation		
Item	**Details**	**DMAS Differences/Comments**
	premiums, deductibles, and co-insurance in a process referred to as buy- in. Under the buy-in process the SMA, the Social Security Administration (SSA), and U.S. Department of Health & Human Services (HHS) enter into a contract where States pay the Medicare beneficiary share of premium costs, and, in some instances, deductibles, and co-insurance. An exchange of eligibility information between Medicare and the SMA initiates Medicare premium payments. The service agreement between the SMA and business partner determines the intervals for this business process to execute. The business process receives eligibility information from Medicare, performs a matching process against the State Medicaid Enterprise member data store, generates buy-in files to Centers for Medicare & Medicaid Services (CMS) for verification, receives premium payment information from and generates payments to CMS. The SMA will pay the private health insurance premiums for members who have private health insurance benefits, if it determines the insurance to be cost effective. In these circumstances, the SMA prepares and sends a premium to the member's private health insurance company. Health insurance premium payment initiates with an application for Medicaid where the applicant indicates they have third-party health coverage or by receiving eligibility information via referrals from Home and Community-Based Services (HCBS) Offices, schools, community services organizations, or phone calls directly from members. The business process checks for	

FM Accounts Payable Management Manage Member Financial Participation		
Item	**Details**	**DMAS Differences/Comments**
	internal eligibility status as well as eligibility with other payers, producing a report identifying individuals where paying premiums would be cost effective, and notifying members via ***Manage Applicant and Member Communication*** business process. **NOTE:** This business process does not include sending the premium payments as an Electronic Data Interchange (EDI) transaction.	
Trigger Event	State transition Trigger Events: • Receive alert of Medicare eligibility from Health Insurance Marketplace. • Receive alert of Medicaid applicant with third-party insurance. Environment-based Trigger Events to include but not limited to: • Periodic timetable is due for receipt of Medicare eligibility information.-yes, receive insurance info from member or through a referral • Periodic timetable (e.g., monthly) is due for insurance premium eligibility redetermination and payments. • Receive insurance information either by the member or through a referral.	Health Insurance Marketplace not used for VA.
Result	• Modification to Medicare buy-in reporting.	

FM Accounts Payable Management		
Manage Member Financial Participation		
Item	**Details**	**DMAS Differences/Comments**
	• Identification of individuals where paying insurance premiums is cost effective. • Alert to send notification of premium payment to member via ***Manage Applicant and Member Communication*** business process. • Alert to send notification of premium payment to Medicaid. • Alert to ***Manage Accounts Payable Information*** business process for conducting premium payment. • If applicable, alert send notification to business partner of member premium payment via ***Manage Business Relationship Communication*** business process. • Tracking information as needed for measuring performance and business activity monitoring.	System generated letter, SSA –eligible for buy in. NA
Business Process Steps	1. **START:** Alert to determine if the State Medicaid Agency (SMA) should pay a member's premium. 2. Prepare Medicaid Premium Payment. a. Receive State Data Exchange (SDX), Enrollment Data Base (EDB) file, and/or the SSA Beneficiary Data Exchange (BENDEX) eligibility files from the **Receive Inbound Transaction**. b. Perform a matching process against the Member data store. c. Generate buy-in file, containing both Medicare Part A and Medicare Part B members (includes all requests for action including discrepancies from previous month). d. Send buy-in file to CMS. e. Receive CMS responses to the buy-in file (i.e., the Billing File for	Also, Part D included

FM Accounts Payable Management		
	Manage Member Financial Participation	
Item	**Details**	**DMAS Differences/Comments**
	both Part A and Part B) including eligible, responses to errors, and Medicare buy-in file information. f. Process CMS responses to the submitted buy-in file and assess the file for accuracy and completeness. g. Post buy-in modifications to the Member data store. h. Produce buy-in reports reflecting potential Medicare eligibles including any additions or deletions to existing Member data store as well as other discrepancies. i. Staff researches unmatched and discrepancies to determine appropriate eligibility. j. Send problem discrepancy form(s) reflecting potential Medicare eligibles, unmatched, and discrepancies to the Buy-in Administration, and update final Medicare buy-in file for internal use. 3. Prepare Health Insurance Premium Payment (HIPP): a. Receive insurance information either from an applicant or through a referral. b. Check internal and external eligibility information. c. Edit eligibility information. d. Determine cost effectiveness by collecting information such as policy coverage, past usage, and by making a determination of future need – the requirements for determining cost effectiveness will vary among States. e. Produce a report of individuals where paying premiums is cost effective for the SMA.	

FM Accounts Payable Management		
	Manage Member Financial Participation	
Item	**Details**	**DMAS Differences/Comments**
	4. Send alert to conduct premium payment to ***Manage Accounts Payable Information*** business process. Medicare buy in is a fed wire transfer done by fiscal. 5. If applicable, send alert to notify member of premium payment via ***Manage Applicant and Member Communication*** business process. 6. If applicable, send alert to notify business partner of member premium payment via ***Manage Business Relationship Communication*** business process. 7. **END:** If applicable, send alert to notify Medicare of member premium payment.	
Shared Data	Financial data store including accounts payable information Health Insurance Marketplace data store including applicant eligibility and member enrollment information (i.e., dual-eligibility) Member data store including demographics, cost share, third-party insurance, and premium information	Health Insurance Marketplace not used for VA.
Predecessor	**Receive Inbound Transaction** ***Determine Member Eligibility***	
Successor	**Send Outbound Transaction** ***Manage Member Information*** ***Manage Applicant and Member Communication*** ***Manage Business Relationship Communication*** ***Manage Accounts Payable Information*** ***Manage Accounts Receivable Information***	

FM Accounts Payable Management		
Manage Member Financial Participation		
Item	**Details**	**DMAS Differences/Comments**
Constraints	The ***Manage Member Financial Participation*** business process will adhere to the federal policies and business rules .	
Failures	• State Medicaid dual eligibility information does not match Medicare dual eligibility information – errors in BENDEX, EDB, or SDX files.	
Performance Measures	• Time to complete process: e.g., Real Time response = within ___ seconds, Batch Responses = within ___ hours • Batch process once a month, 10 days to turn around for Medicare buy in • Accuracy with which rules are applied =100_% • Consistency with which rules are applied =100 ___% • Error rate = 0 ___ % or less	• No real time transactions used for VA • 10 days for batch • 100% accuracy • 100% consistency • 0% error rate

3.5.2.2.2 As-Is Assessment

The overall rating for the Manage Member Financial Participation business process is '2.' DMAS adheres to the process as described in the BPM, with the exception that the SDX and EDB exchange files are not used by Virginia Medicaid. However the BENDEX eligibility file is used.

Other items noted in the As-Is assessment were:

- Based on a high dependency on manual processes, accuracy and consistency of data are low
- The Health Insurance Marketplace is not used by DMAS
- The process includes premium payments for Part D

3.5.2.2.3 To-Be Assessment

DMAS intends to improve the Manage Member Financial Participation business process to Level 3.

Specific changes identified include:

- Implement additional automation in the process to improve timeliness from 10 days closer to the 24 hour objective
- Collaboration and electronic information sharing
- Identify and capture performance measures and use them to identify additional improvements.

3.5.2.2.4 Scorecard

The following scorecard was compiled for the Manage Member Financial Participation business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payable Management Manage Member Financial Participation	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	1	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		

Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.2.3 Manage Capitation Payment

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Capitation Payment business process.

3.5.2.3.1 Business Process Model

The Manage Capitation Payment business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Payable Management		
Manage Capitation Payment		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Capitation Payment*** business process includes the activities to prepare Primary Care Case Management (PCCM) or Managed Care Organization (MCO) capitation payments. Some States offer members the option of enrolling in a PCCM product that requires the selection of a Primary Care Physician (PCP). The PCP receives a Per-Member-Per-Month (PMPM) capitation payment amount for all members that the State Medicaid Agency (SMA) assigns. The provider payment schedule defines the PCCM capitation rates typically actuary based on an age and gender rating or flat rate. Provider may opt in or out of PCCM plan and does not have to belong to the MCO. A prevailing alternative to the SMA integrated managed care model is to delegate specific member populations to MCOs and pay the MCO a PMPM capitation amount for all assigned members. The ***Manage Capitation Payment*** business process interrogates the member, provider, and MCO, member assignment and	

FM Accounts Payable Management		
Manage Capitation Payment		
Item	**Details**	**DMAS Differences/Comments**
	contract capitation information, and creates the information extract necessary to generate the capitation payment. The data extract includes any processing rules and options including retroactive adjustments to member assignments that affect the capitation payment amount to the provider or MCO.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic (e.g., monthly) timetable to conduct capitation information extract.	
Result	• Alert sent to ***Manage Accounts Payable Information*** business process to generate Provider/MCO capitation payments. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Timed event triggered on monthly basis to initiate ***Manage Capitation Payment*** business process to invoke capitation information extract. 2. **END:** Send alert to ***Manage Accounts Payable Information*** business process to generate provider/MCO capitation payments.	
Shared Data	Financial data store including accounts payable information Contractor data store including contract information Member data store including eligibility and benefits information Provider data store including provider network & contract information	Rate Data also included as Shared Data. Rates set each year effective July. No Kick Payments made for VA

FM Accounts Payable Management		
Manage Capitation Payment		
Item	**Details**	**DMAS Differences/Comments**
		process.
Predecessor	***Enroll Member***	
Successor	***Manage Accounts Payable Information***	
Constraints	The ***Manage Capitation Payment*** business process will adhere to the federal and state policies and business rules that may differ by state.	
Failures	• No PCP information is available. • No PCCM information is available.	
Performance Measures	• Time to complete the process: e.g., Real Time response = within _____ seconds, Batch Response = within _____hours • Accuracy with which rules are applied =_____ • Consistency with which rules are applied=_____% • Error rate =____% or less	Must be ready for payments by 22nd each month. 100% accuracy 100% consistency 0% error rate

3.5.2.3.2 As-Is Assessment

The overall rating for the Manage Capitation Payment business process is '3.' Capitation claims are paid by the 22nd of each month; this is ensured through the production schedule.

Other items noted in the As-Is assessment were:

- Capitation payments are reflected in an X12 820 transaction file
- Results are considered to be 100% accurate since claims are system-generated and use the data

available, including capitation rates.

3.5.2.3.3 To-Be Assessment

DMAS will investigate cost-beneficial enhancements to improve the Manage Contractor Payment business process within its overall Level 3 rating.

Specific changes identified include:

- Implement additional automation in the process
- Use increased collaboration and electronic information sharing to improve timeliness
- Identify and capture performance measures and use them to identify additional improvements.

3.5.2.3.4 Scorecard

The following scorecard was compiled for the Manage Capitation Payment business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payable Management Manage Capitation Payment	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	3	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	3	3
Performance Measure		
Supporting Evidence Reference		

Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		
Supporting Evidence Reference		

3.5.2.4 Manage Incentive Payment

The Manage Incentive Payment business process is not applicable to the Virginia Medicaid program.

3.5.2.5 Manage Accounts Payable Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Accounts Payable Information business process.

3.5.2.5.1 Business Process Model

The Manage Accounts Payable Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Payable Management		
Manage Accounts Payable Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Accounts Payable Information*** business process is responsible for all operational aspects of money the State Medicaid Agency (SMA) pays. Activities in this business process comply with Cash Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP). Activities included in this process may be: • Periodic reconciliations between the State Medicaid Enterprise and	

FM Accounts Payable Management		
Manage Accounts Payable Information		
Item	**Details**	**DMAS Differences/Comments**
	the system(s) that performs accounting functions. • Assignment of account coding to transactions processed in the State Medicaid Enterprise. • Processing accounts payable invoices created in the State Medicaid Enterprise. • Processing accounts payable invoices created in state accounting system (gross adjustments or other service payments not processed through the State Medicaid Enterprise, and administrative payables). • Loading accounts payable information (warrant number, date, etc.) into the State Medicaid Enterprise. • Managing canceled/voided/stale dated warrants. • Performing payroll activities. • Disbursing federal administrative costs reimbursements to other entities. • Responding to inquiries concerning accounting activities. **NOTE:** States use a variety of solutions including outsourcing to another department or use of a Commercial-Off-the-Shelf (COTS) package.	DMAS does not do payroll activities.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive request for payment. • Receive accounts payable information.	
Result	• Modification to accounts payable information. • Alert sent to disburse payment to ***Manage Accounts Payment Disbursement*** business process. • If applicable, alert sent to ***Establish Compliance Incident*** business process for a member's, provider's or contractor's continued failure to make payment. • Tracking information as needed for	

FM Accounts Payable Management		
Manage Accounts Payable Information		
Item	**Details**	**DMAS Differences/Comments**
	measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request and information to make payment. 2. Perform requested function. 3. Produce report. 4. If applicable, alert sent to ***Establish Compliance Incident*** business process for continued failure to make obligated payments. 5. Produce financial transaction. 6. Update financial information. 7. Send alert to make payment to ***Manage Accounts Payment Disbursement*** business process. 8. **END:** Send response to requested function.	
Shared Data	State accounting system accounts payable information Financial data store including payroll, general ledger, and accounts payable information Claims data store including payment information Contractor data store including contract information Member data store including demographics information Provider data store including provider network information	
Predecessor	**Receive Inbound Transaction** ***Manage Contractor Payment*** ***Manage Incentive Payment*** ***Manage Member Financial Participation*** ***Manage 1099*** ***Manage Capitation Payment***	

FM Accounts Payable Management		
Manage Accounts Payable Information		
Item	**Details**	**DMAS Differences/Comments**
Successor	**Send Outbound Transaction** ***Manage Accounts Payment Disbursement*** ***Generate Financial Report*** ***Establish Compliance Incident*** ***Manage Data***	
Constraints	The SMA will follow federal and state-specific accounting and financial requirements.	
Failures	• Failure to account for expenditures in accordance with GAAP can result in disallowance of federal funding participation.	
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___ seconds, Batch Response = within _____h ours • Accuracy with which rules are applied =100 _____ % • Consistency with which rules are applied= _100___ % • Error rate = __0__ % or less	• No legal requirement to complete the process within a certain time. • 100% accuracy • 100% consistency • 0% error rate

3.5.2.5.2 As-Is Assessment

The overall rating for the Manage Accounts Payable Information business process is '2.' Many business capabilities were rated higher, but the timeliness and data access and accuracy precluded a higher overall assessment. The process accuracy was identified as 100%, and it is considered highly efficient and effective by the business area.

Other items noted in the As-Is assessment were:

- The DMAS business process conforms to the BPM, with the exception that we do not perform any payroll activities
- There no legal requirements related to the timeliness of the process.

3.5.2.5.3 To-Be Assessment

DMAS intends to improve the Manage Accounts Payable Information business process to an overall Level 3 rating.

Specific changes identified include:

- Implement additional automation in the process
- Explore the feasibility of utilizing electronic claims attachments as a source of information
- Use increased collaboration and electronic information sharing to improve timeliness
- Identify and capture performance measures and use them to identify additional improvements.

3.5.2.5.4 Scorecard

The following scorecard was compiled for the Manage Accounts Payable Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payable Management Manage Accounts Payable Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	3	3
Performance Measure		
Supporting Evidence Reference		

Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		
Supporting Evidence Reference		

3.5.2.6 Manage Accounts Payable Disbursement

The following sections provide the business process
s model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Accounts Payable Disbursement business process.

3.5.2.6.1 Business Process Model

The Manage Accounts Payable Disbursement business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Payable Management		
Manage Accounts Payable Disbursement		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Accounts Payable Disbursement*** business process that is responsible for managing the generation of electronic and paper-based reimbursement instruments, includes: • Calculation of payment amounts fee-for-service claims, pharmacy point-of-sale, and Home and Community-Based Services (HCBS) based on: o Priced claim, including any Third-Party Liability (TPL), and crossover or member payment adjustments. o Retroactive rate adjustments. o Adjustments for previous incorrect payments, taxes, performance incentives, recoupments, garnishments, and liens based on	No taxes are done through this process. No payroll processing is done by SMA. Medicare premiums done by Federal Wire transfer outside of MMIS. No Stop Loss Payment SMA does not refund the

FM Accounts Payable Management		
	Manage Accounts Payable Disbursement	
Item	**Details**	**DMAS Differences/Comments**
	information in the Provider data store, as well as state accounting and budget rules. o Payroll processing (e.g., for HCBS providers) which includes withholding payments for payroll, federal and state taxes, as well as union dues. o Application of automated or user-defined adjustments based on contract (e.g., adjustments or performance incentives). • Disbursement of payment from appropriate funding sources per state and the State Medicaid Agency (SMA) accounting and budget rules including: o Managed Care Organization (MCO) per member per month premium. o Health Insurance Premium Payment (HIPP) Program premium. o Medicare premium. o Primary Care Case Managers (PCCM) fee. o Stop-loss payment. o PCCM management fee. o Health Insurance Flexibility and Accountability (HIFA) waiver small employer refunds (i.e. Parents of children enrolled in Children's Health Insurance Program (CHIP)). • If applicable, association of the Electronic Funds Transfer (EFT) with an Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice or ASC X12 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction. • Routing of the payment per the provider or contractor data store payment instructions for EFT or check generation and mailing. • Alert sent to the ***Manage Accounts Payable Information*** business process	employer. CD payroll services are performed by contractor PPL. CD Payroll services are not disbursed in MMIS but are disbursed outside MMIS via CARS (State accounting system) by Oracle Financials. Stop-loss and PCCM management fees are not done by SMA. Health Insurance Flexibility and Accountability (HIFA) waiver small employer refunds (i.e. Parents of children enrolled in Children's Health are not addressed

FM Accounts Payable Management		
Manage Accounts Payable Disbursement		
Item	**Details**	**DMAS Differences/Comments**
	with updated suspended and paid claims transaction accounting details. • Alert sent to the ***Manage Accounts Payable Information*** business process with updated suspended and paid premium, fees, and stop-loss claims transaction accounting details. he SMA will support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real-time payments where appropriate (e.g., Pharmacy Point-of-Sale).	
Trigger Event	State transition Trigger Events**:** • Receive payment request from the ***Process Claim*** business process. • Receive payment request from the ***Process Encounter*** business process. • Receive premium fee or stop-loss claim information from the ***Manage Member Financial Participation*** or ***Prepare Provider Payment*** business processes. Environment-based Trigger Events to include but not limited to: • Receive payment request.	No Stop-loss payments done by SMA
Result	• Provider or contractor received payment either by EFT or check. • Alert sent to send ASC X12 820 Payment Order/Remittance Advice transaction for payment to provider or contractor. • Tracking information as needed for measuring performance and	

FM Accounts Payable Management		
Manage Accounts Payable Disbursement		
Item	**Details**	**DMAS Differences/Comments**
	business activity monitoring.	
Business Process Steps	1. **START:** Receive request for payment. 2. Prepare provider payment: a. Receive payment information from the ***Process Claim*** or ***Process Encounter.*** b. Apply automated or user-defined payment calculation rules (e.g., deducting tax per rates in provider files, garnishments, and liens) by accessing information from provider files and sending an alert to the ***Manage Accounts Payable Information*** business process. c. For payroll processing, perform tax withholds and generate information for accounting. 3. Prepare premium payment: a. Receive premium payment information from the ***Manage Member Financial Participation*** or ***Prepare Provider Payment*** business processes. b. Apply automated or user-defined payment calculation rules such as risk adjustment and stop-loss claims, retrospective enrollment, and performance incentives. 4. Disburse funds as specified by the state and the SMA accounting and budget business rules. 5. **END:** Route payments as specified by the provider or contractor pay-to instruction or based on information	Taxes are not done. No Stop-loss payments done by SMA

FM Accounts Payable Management		
Manage Accounts Payable Disbursement		
Item	**Details**	**DMAS Differences/Comments**
	submitted in the standard claim transactions.	
Shared Data	Claims data store including payment information Health Benefit data store including benefit information and fee schedules Provider data store including demographic, tax, pay-to and payment routing instructions, liens, garnishments, adjustments, incentives, rates, and contract information Authorization data store including authorization and treatment plan information Contractor data store including demographic, tax, pay-to and payment routing instructions, liens, garnishments, adjustments, incentives, reimbursement arrangements, rates, stop-loss claim payments, and contract information Financial data store including accounting rules, rates, and funding sources Member data store including demographics information	Taxes are not done. No Stop-loss payments done by SMA
Predecessor	***Manage Accounts Payable Information*** ***Manage Provider Information*** ***Process Claim*** ***Process Encounter*** ***Manage Performance Measures*** ***Generate Remittance Advice*** ***Manage Member Financial Participation*** ***Prepare Provider Payment***	
Successor	**Send Outbound Transaction**	

FM Accounts Payable Management		
Manage Accounts Payable Disbursement		
Item	**Details**	**DMAS Differences/Comments**
	Manage Accounts Payable Information ***Manage Performance Measures***	
Constraints	States apply different tax and accounting rules to this business process. Some will not do payroll processing or have performance incentives. Some may associate EFTs with remittance advice transactions. Some will not have an MCO premium or MCO capitation, a PCCM fee, stop-loss, or performance incentives. Some may associate EFTs with premium payment transactions.	Taxes are not done. No Stop-loss payments done by SMA
Failures	• Calculation of payment and application of payment adjustments may lack accurate information or be inaccurate. • Entity failed to receive EFT or check, the check is not payable due to insufficient funds, or payee returns the check. • Unable to process payment due to a mutilated, destroyed or stale dated check.	
Performance Measures	• Time to complete process = within days • Accuracy with which the SMA applies edits = _100__% • Consistency of decisions and disposition = 100_____ • Error rate = _0__% or less	MMIS related payments are generated with a paid date 1 week later than weekly payment cycle. CD Payroll payments paid outside MMIS are paid every week by 10 days after receipt of invoice. Medicare Premiums are due to CMS by the date indicated as due date on invoice. Accuracy/Consistency = 100% Error rate = 0%

3.5.2.6.2 As-Is Assessment

The overall rating for the Manage Accounts Payable Disbursement business process is '2.' Some business capabilities were rated higher, but the timeliness and data access and accuracy precluded a higher overall assessment. The process accuracy was identified as 100%, and it is considered efficient and effective by the business area, but there is not yet complete compliance with the MITA Framework.

Other items noted in the As-Is assessment were:

- The DMAS business process is not used to pay taxes, make stop-loss payments or pay Health Insurance Flexibility and Accountability (HIFA) waiver small employer refunds
- PPL (CD-PAS & MFP) is paid via Oracle / CARS for the "payroll" activity (weekly) and PPL is also paid via MMIS for the monthly (PMPM) cost.
  - The PPL weekly payroll invoices are paid via Oracle and checks cut by the Department of Accounts (CARS).
  - The PMPM monthly costs are captured in the MMIS and paid through the remittance process.

3.5.2.6.3 To-Be Assessment

DMAS intends to improve the Manage Accounts Payable Disbursement business process to an overall Level 3 rating.

Specific changes identified include:

- Utilize standard EFT transactions for all payments
- Implement additional automation in the process
- Use increased collaboration and electronic information sharing to improve timeliness
- Identify and capture performance measures and use them to identify additional improvements.

3.5.2.6.4 Scorecard

The following scorecard was compiled for the Manage Accounts Payable Disbursement business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payables Management Manage Accounts Payable Disbursement	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		

Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	3	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		
Supporting Evidence Reference		

3.5.2.7 Manage 1099

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage 1099 business process.

3.5.2.7.1 Business Process Model

The Manage 1099 business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Accounts Payable Management
Manage 1099

Item	Details	DMAS Differences/Comments
Description	The ***Manage 1099*** business process describes how the State Medicaid Agency (SMA) handles IRS 1099 forms including preparation, maintenance, and corrections. Any payment or adjustment in payment made to a single Social Security Number (SSN) or federal Tax ID Number (TIN) impacts the business process. The ***Manage 1099*** business process receives payment and/or recoupment information from the ***Process Claim*** business process or from the ***Manage Accounts Payable Information*** business process. The ***Manage 1099*** business process may also receive requests for additional copies of a specific IRS 1099 form or receive notification of an error or a needed correction. The business process provides additional requested copies via the ***Manage Provider Communication*** or ***Manage Contractor Communication*** business processes. Staff researches error notifications and requests for corrections for validity and generate a corrected 1099 or a brief explanation of findings.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Request from a provider, state or federal agency. • End of the calendar year. State transition Trigger Events: • Receive information from ***Process Claim*** or ***Manage Accounts Payable Information*** business processes indicating payments and/or recoupments. • Receive information from ***Manage Provider Information*** business process for modifications. • Receive information from ***Manage***	

FM Accounts Payable Management		
Manage 1099		
Item	**Details**	**DMAS Differences/Comments**
	Contractor Information business process for modifications.	
Result	• Updated and/or corrected 1099 information (i.e., form, file, paper, or Electronic Data Interchange (EDI) sent to providers, contractors, Internal Revenue Service (IRS), and other state agencies. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	Preparation/Maintenance 1. **START:** Receive claim payment and adjustment information from ***Process Claim*** or ***Manage Accounts Payable Information*** business process. 2. Match TIN or SSN. 3. Update cumulative totals by applying all payments and recoupments, including those from cost settlements and manual checks. a. Prepare report of those not getting a 1099. b. Produce master report of 1099s. c. Review all 1099 reports for accuracy. 4. Prepare 1099 at close of calendar year. 5. Send 1099 to appropriate providers and contractors prior to January 31. 6. **END:** Submit 1099 information to Internal Revenue Service (IRS).	

FM Accounts Payable Management		
	Manage 1099	
Item	**Details**	**DMAS Differences/Comments**
	Alternate Path - Additional Requests 1. **START:** Receive request for additional 1099(s). 2. Agency logs request. 3. Verify identity of requesting entity. 4. Re-generate requested 1099(s). 5. Send 1099 to requesting entity. 6. **END:** Agency logs 1099(s) sent. Alternate Path - Corrections 1. **START:** Receive notification of error or modification request from ***Manage Provider Information*** or ***Manage Contractor Information*** business processes 2. Agency logs request. 3. Verify identity of requesting entity. 4. Research error or update request. 5. If no error found, send alert to notify requesting entity of findings. **END:** Business process stops. 6. If error found valid, make necessary modifications. 7. Prepare corrected or updated 1099. 8. Agency logs 1099 sent.	

FM Accounts Payable Management		
	Manage 1099	
Item	**Details**	**DMAS Differences/Comments**
	9. Send corrected 1099 to affected parties. 10. **END:** Submit corrected 1099 information to Internal Revenue Service (IRS).	
Shared Data	Financial data store including accounts payable information Claim data store including payment information Contractor data store including demographics and 1099 information Provider data store including demographics and 1099 information 1099 Information sent to Internal Revenue Service (IRS)	
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Manage Accounts Payable Information*** ***Manage Provider Information*** ***Manage Contractor Information***	
Successor	**Send Outbound Transaction** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Manage Accounts Payable Information***	
Constraints	The SMA will follow IRS regulations regarding 1099 requirements..	
Failures	• Invalid format or media used.	
Performance	• Time to complete process: e.g., Real Time	

FM Accounts Payable Management		
Manage 1099		
Item	**Details**	**DMAS Differences/Comments**
Measures	response = within ___ seconds, Batch Responses = within ___ hours • Accuracy of decisions =100_% • Consistency of decisions and disposition =100% • Error rate = _0__ % or less	1099s must be mailed by January 31; the process usually takes <= 3 weeks 100% accuracy 100% consistency 0% error rate

3.5.2.7.2 As-Is Assessment

The overall rating for the Manage 1099 business process is '2.' DMAS performs all of the steps defined in the BPM using a mix of manual and automatic processes. The process conforms to IRS standards.

Other items noted in the As-Is assessment were:

- The data and results accuracy were identified as 100%
- The 1099s are provided as paper documents only.

3.5.2.7.3 To-Be Assessment

DMAS intends to improve the Manage 1099 business process to an overall Level 3 rating.

Specific changes identified include:

- Determine if further automation of the process is possible with cost-beneficial results
- Use increased collaboration and electronic information sharing to improve timeliness, including providing 1099 information in a paperless manner
- Identify and capture performance measures and use them to identify additional improvements.

3.5.2.7.4 Scorecard

The following scorecard was compiled for the Manage 1099 business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payables Management Manage 1099	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.5.3 Fiscal Management

As shown in Figure 3.5-1, the Fiscal Management business category is made up of four business processes:

- Formulate Budget

- Manage Budget Information
- Manage Fund
- Generate Financial Report.

Details regarding the assessment of each Fiscal Management business process follow.

3.5.3.1 Formulate Budget

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Formulate Budget business process.

3.5.3.1.1 Business Process Model

The Formulate Budget business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Fiscal Management		
Formulate Budget		
Item	**Details**	**DMAS Differences/Comments**
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. • Periodically produces a new budget.	DMAS does annually.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., annual) is due for budget review.	2nd bulleted item not part of business process for VA.

FM Fiscal Management		
Formulate Budget		
Item	**Details**	**DMAS Differences/Comments**
	• Receive review request from external forces (e.g., notice of revenue shortfall or overage and/or unforeseen rise in costs).	
Result	• New or revised budget. • Tracking information as needed for measuring performance and business activity monitoring.	2nd bulleted item done is an ongoing yearly process for VA.
Business Process Steps	1. **START**: Receive notice or other trigger event to prepare the Office of Governor budget transmittal for Legislative approval. 2. Review current budget including cost and revenue trends, Centers for Medicare & Medicaid Services (CMS) notification of federal grant award, demographics, utilization, and other information. 3. Research factors (e.g., national, legislative, and global) that affect the State Medicaid Agency (SMA) revenue, costs, major initiatives, and benefits. 4. Develop and send Office of Governor budget transmittal. 5. Testify before state legislature and/or convene stakeholders to consider alternatives. 6. Model or modify budget transmittal based on legislative or Office of Governor directives. 7. Legislature publishes finalized budget.	Item 2 updates used for forecast processes for VA.

FM Fiscal Management		
Formulate Budget		
Item	**Details**	**DMAS Differences/Comments**
	8. **END**: Enter approved budget into state accounting system and other expenditure accounting systems.	Entry of budget information into state accounting system (CARS) done by VA's Department of Planning and Budget.
Shared Data	Financial data store including budget information Business Activity data store including performance information Plan data store including plan information Health Benefit data store including benefit information	PULSE used to maintain the Financial and Business Activity data stores. MMIS is used mainly for the Plan and Health Benefit data stores along with SAS data
Predecessor	***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures***	
Successor	***Manage Budget Information*** ***Manage Health Plan Information*** ***Manage Health Benefit Information***	
Constraints	The SMA will follow federal and state requirements for budget management. Economic conditions shift, making less revenue available to fund the approved and planned budget.	
Failures	• Failure to receive all levels of required approval (that could result in continued use of previously approved budget).	

FM Fiscal Management		
Formulate Budget		
Item	**Details**	**DMAS Differences/Comments**
Performance Measures	• Time to complete process = within days • Accuracy with which edits are applied = 100% • Consistency of decisions and disposition =____% • Accuracy of budget projections measured against reality =_____%	Time - N/A, Process timeline is August through June for each state fiscal year. Consistency of Decisions – N/A, based on VA general Assembly actions. Accuracy of Budget Projections – N/A, not done for projected year for VA

3.5.3.1.2 As-Is Assessment

The overall rating for the Formulate Budget business process is '3.' This is a scheduled annual process that adheres to the defined BPM, although revisions to an approved budget are not typically made. Budget information is entered into the State accounting system (CARS). A new system, called PULSE, was recently implemented that supports budget reporting using information extracted from CARS.

Other items noted in the As-Is assessment were:

- The timeline for formulating and finalizing the budget information is August through June
- The level of automation used exceeds the Level 2 definition
- The budget that is loaded is 100% accurate
- The implementation of PULSE for state use increased the data accuracy and access.

3.5.3.1.3 To-Be Assessment

DMAS intends to maintain a Level 3 rating for the Formulate Budget business process, but will look for opportunities for improvement.

Specific changes identified include:

- Determine if further automation of the process is possible with cost-beneficial results
- Pursue increased collaboration and electronic information sharing to improve timeliness

- Identify and capture performance measures and use them to identify additional improvements.

3.5.3.1.4 Scorecard

The following scorecard was compiled for the Formulate Budget business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Receivable Management Formulate Budget	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	3	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	3	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		

Supporting Evidence Reference	

3.5.3.2 Manage Budget Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Budget Information business process.

3.5.3.2.1 Business Process Model

The Manage Budget Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Fiscal Management		
Manage Budget Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Budget Information*** business process is responsible for auditing all planned expenses and revenues of the State Medicaid Agency (SMA). Activities in this business process comply with Cash Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP).	VA's assumption is managing the current state Fiscal Year Budget, not a new FY, from July through June, otherwise the process is identical to the Formulate Budget Process.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive request to review budget information (e.g., funding requirements, funding sources).	
Result	• Modified budget information. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process	1. **START:** Receive request to review or modify approved budget.	

FM Fiscal Management		
Manage Budget Information		
Item	**Details**	**DMAS Differences/Comments**
Steps	2. Review policies and procedures for planning and budgeting to determine if budget meets state and federal requirements. 3. Review long-term goals and objectives plans. 4. Review budget to determine accurate and timely information. 5. Review budget performance monitoring information. 6. Review budget revisions to determine their justification and the SMA makes in a timely manner. 7. Prepare budget modification request to Office of Governor based on state budget policies. 8. Receive approval from Office of Governor to modify budget. 9. **END:** Modify budget information as necessary.	
Shared Data	Financial data store including accounts payable, accounts receivable, and budget information	
Predecessor	***Formulate Budget*** *Manage Fund* ***Manage Health Plan Information*** ***Manage Health Benefit Information***	

FM Fiscal Management		
Manage Budget Information		
Item	**Details**	**DMAS Differences/Comments**
Successor	***Generate Financial Report*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Data***	
Constraints	The SMA will follow federal and state requirements for budget management. Economic conditions shift, making less revenue available to fund the approved and planned budget.	
Failures	• This business process has no failure modes that prevent the process from going to completion.	
Performance Measures	• Time to complete process = within days • Accuracy with which edits are applied = 100__% • Consistency of decisions and disposition =_____ • Error rate = _0_% or less	Time - N/A, Process timeline is July through June for each state fiscal year. Consistency of Decisions – N/A

3.5.3.2.2 As-Is Assessment

The overall rating for the Manage Budget Information business process is '3.' DMAS does not typically revise a budget once it is established, so managing the budget information is considered to be equivalent to formulating the budget. For the purposes of this assessment, the two processes were essentially considered to be one and the same, so the assessment results are virtually the same as well.

Other items noted in the As-Is assessment were:

- The Manage Budget Information process was assumed to refer to the 'current' fiscal year; once

established a budget is not revised
- The State fiscal year is July through June
- The level of automation used exceeds the Level 2 definition
- The budget that is used is 100% accurate
- The implementation of PULSE for state use increased the data accuracy and access.

3.5.3.2.3 To-Be Assessment

DMAS intends to maintain a Level 3 rating for the Manage Budget Information business process, but will look for opportunities for improvement.

Specific changes identified include:

- Determine if further automation of the process is possible with cost-beneficial results
- Pursue increased collaboration and electronic information sharing to improve timeliness
- Identify and capture performance measures and use them to identify additional improvements.

3.5.3.2.4 Scorecard

The following scorecard was compiled for the Manage Budget Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Receivable Management Manage Budget Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	3	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	3	3
Performance Measure		
Supporting Evidence Reference		

Effort to Perform; Efficiency	3	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		
Supporting Evidence Reference		

3.5.3.3 Manage Fund

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Fund business process.

3.5.3.3.1 Business Process Model

The Manage Fund business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Fiscal Management		
Manage Fund		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Fund*** business process oversees Medicaid funds, ensures accuracy in their allocation and the reporting of funding sources. Funding for Medicaid services may come from a variety of sources, and often, state funds span across state agency administrations, e.g., Mental Health, Aging, Substance Abuse, physical health, as well as state counties and local jurisdictions. The ***Manage Fund*** business process monitors funds through ongoing tracking and reporting of expenditures and corrects any improperly accounted expenditure. It also deals with projected and actual over and under fund allocations.	

FM Fiscal Management		
	Manage Fund	
Item	**Details**	**DMAS Differences/Comments**
	Manage Federal Medical Assistance Percentages (FMAP) The Manage FMAP activity periodically reviews and modifies, as appropriate, FMAP and Enhanced Federal Medical Assistance Percentages (enhanced FMAP) rate used. (See 42 CFR 433.10). The U.S. Department of Health & Human Services (HHS) notifies the state of the FMAP (and enhanced FMAP) that HHS will use in determining the amount of federal matching for state medical assistance (Medicaid), Children's Health Insurance Program (CHIP), and Recovery Audit Contractor (RAC) expenditures for a specified federal fiscal year. The State Medicaid Agency (SMA) reviews and approves the FMAP rates for application in enterprise accounting. Manage Federal Financial Participation (FFP) The Manage FFP business activity includes the creation and management of business rules for assigning claims, service payments, and recoveries (including RAC recoveries) to the appropriate FMAP, and the application of administrative costs to the state accounting system. It also includes the oversight of reporting and monitoring Advance Planning Documents or other program documents necessary to secure and maintain FFP. Draw and Report FFP The Draw and Report FFP business activity assures that the SMA properly draws federal funds and reports to Centers for Medicare & Medicaid Services (CMS). The SMA is responsible for assuring that the correct FFP rate applies to all expenditures in determining the amount of federal funds to draw. When CMS has approved a Medicaid State Plan, it makes quarterly grant awards to the SMA to cover the federal share of expenditures for services, training, and administration. The grant award	Children's Health Insurance Program (CHIP) is called FAMIS by DMAS HMS is the Recovery Audit Contractor (RAC)

FM Fiscal Management		
	Manage Fund	
Item	**Details**	**DMAS Differences/Comments**
	authorizes the SMA to draw federal funds as needed in accordance with the Cash Management Improvement Act (CMIA) to pay the federal share of disbursements. The SMA receives FFP in expenditures for the CHIP program.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • A request from the legislature, or a new budget approved. • Periodic timetable (e.g., weekly, monthly, quarterly, annual, 3-year plan, 5-year plan) is due for generating required reports. • Receive new match rates or rate modifications from HHS. • Receive notification to apply FMAP rate to service expenditures or recoveries. • Periodic timetable (e.g., quarterly) is due for a statement of expenditures. • Continuous oversight of expenditures for an FFP. • The SMA adds a new health plan or health benefit. • Periodic timetable is due for an audit.	Request from governor rather than the legislature CMS-64
Result	• Tracking and trending of all program expenditures and management of them within budget constraints. • Produces updated FMAP. • Service expenditure and recovery information with applied FMAP rate.	

FM Fiscal Management		
	Manage Fund	
Item	**Details**	**DMAS Differences/Comments**
	• Calculation of FFP available for all eligible members, systems, and administration of the State Medicaid Enterprise. • Content prepared for the following reports: o CHIP Program Budget Report (CMS-21B) o Medicaid Program Budget Report (CMS-37) o Quarterly CHIP Statement of Expenditures (CMS-21) o Quarterly Expense Report (CMS-64) **NOTE**: The ***Generate Financial Report*** business process generates and sends the CMS report. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	<u>Manage Fund</u> 1. **START:** Establish state appropriation for federal and state funds. 2. Allocate funds to direct and indirect budget categories. 3. Establish reporting requirements. 4. Define report content, frequency, and media. 5. Prepare the information.	These processes are shared by two Divisions – Budget and Fiscal.

FM Fiscal Management		
	Manage Fund	
Item	**Details**	**DMAS Differences/Comments**
	6. Compare fund usage with categories, flag funds improperly used. 7. Trend rate of usage of funds versus amounts available, flag-computed shortfalls. 8. Generate defined reports. 9. Review reports for accuracy. 10. Distribute reports. 11. **END:** Review trends and improper use of funds, and manage funds as needed to deal with shortfalls and over allocations. <u>Manage FMAP</u> 1. **START:** Receive notification of FMAP rates or rate modifications. 2. Review and analyze notification. 3. Verify accuracy of rates in notification. 4. Notify HHS of any disagreement. 5. Resolve any disagreement with HHS. 6. **END:** Publish/load approved rates. <u>Manage FFP</u> 1. Prepare information necessary to create the reports (e.g., CMS-21, CMS-37 and CMS-64). 2. Generate reports. 3. Review generated reports for accuracy and deficiencies. 4. Monitor expenditures, cost, budget, and so forth.	

FM Fiscal Management		
	Manage Fund	
Item	**Details**	**DMAS Differences/Comments**
	5. Analyze potential program additions, modifications, or deletions for fiscal impact. 6. Modify and update impacted reports and budget. 7. Finalize report. 8. **END:** Send report via the **Send Outbound Transaction.** Draw and Report FFP 1. **START:** Submit Form CMS–37 and Form CMS–21B through the Medicaid Budget and Expenditure System/CHIP Budget and Expenditure System (MBES/CBES). 2. Review the quarterly grant request. 3. Receive the grant award from CMS regardless of whether there are open issues with CMS. The Payment Management System (PMS) deposits funds into the Medicaid account based upon the CMS 37 estimates. 4. Determine the federal share of current expenditures taking into consideration receipts (e.g. estate recovery, recoupments of incorrect billings) and draw federal funds in accordance with the terms of the CMIA. 5. At end of each quarter, complete cash management reconciliation using the PMS 272 report. 6. Submit Form CMS–64 and Form CMS–21 to MBES/CBES. 7. CMS may increase or decrease the grant request amount already deposited according to the resolution of issues process. The SMA sends supporting documentation to the CMS Regional	The PMS 272 is now the PMS 425. It is essentially the same report and is still utilized by the Grants Management area. DMAS is an AGA (annual grant award) state, which results in some annual versus quarterly processes.

FM Fiscal Management		
	Manage Fund	
Item	**Details**	**DMAS Differences/Comments**
	Office for use in its quarterly review to support State Medicaid Enterprise numbers and to address deferrals, disallowances, supplemental payment. 8. The SMA cooperates with CMS reviews of program and administration expenditures and implements corrective action if CMS Financial Management Review (FMR) or Office of Inspector General reviews reveal any federal requirement compliance problems. 9. Arrange for annual Single Audit for the Comprehensive Annual Financial Report conducted by a state-contracted Certified Public Accountant (CPA) firm in accordance with the provisions of OMB Circular A-133. 10. **END:** Follow-up and corrective action(s) on audit findings includes the preparation of a summary schedule of prior audit findings and submission of a Corrective Action Plan (CAP).	Performed by Virginia Auditor of Public Accounts (APA). The DMAS Internal Auditor coordinates all correction actions.
Shared Data	Financial data store including budget, accounts receivable, and accounts payable information Plan data store including health plan information Health Benefit data store including benefit package and benefits information State Financial Management Applications Reference data store including code sets information	
Predecessor	**Receive Inbound Transaction** ***Manage Health Plan Information*** ***Manage Health Benefit Information***	
Successor	**Send Outbound Transaction** ***Manage***	

FM Fiscal Management		
	Manage Fund	
Item	**Details**	**DMAS Differences/Comments**
	Accounts ***Receivable*** ***Information*** ***Manage*** ***Accounts*** ***Payable*** ***Information***	
Constraints	State legislative or agency policies augment the information. FMAP applies to Medicaid expenditures for services under the Medicaid State Plan with the exception of the following: family planning services, services provided through Indian Health Service facilities, services provided to members eligible under the optional Breast and Cervical Cancer program, and Medicare Part B premiums for Qualified Individuals. Manage FFP will conform to state-specific and CMS FFP assignment requirements.	Indian Health Services are not supported
Failures	• The SMA lacks money for budget or is short of revenue. • Natural disaster strikes impacting budget management. • System failure prevents new rates from loading or rates are loaded incorrectly. • The SMA encounters errors in FMAP rate or assignment of rate to individual services. • The SMA is unable to balance reports. • The SMA is unable to access all information required for reporting.	

FM Fiscal Management		
Manage Fund		
Item	**Details**	**DMAS Differences/Comments**
	• There are discrepancies in information invalidate FFP calculations.	
Performance Measures	• Time to complete process: e.g., Real Time response = within seconds, Batch Response = within hours • Accuracy of decisions =___% • Consistency of decisions and disposition = ___% • Error rate = __% or less	N/A - The ***Manage Fund*** process is an on-going process that is comprised of multiple activities throughout the year. 99% accuracy 100% consistency 1% error rate The above measures are estimated based on our understanding of the actual results over time.

3.5.3.3.2 As-Is Assessment

The overall rating for the Manage Fund business process is '2.' This is an on-going process that is comprised of multiple activities throughout the year. The processes are shared by two DMAS divisions: Fiscal and Budget. DMAS is an AGA (annual grant award) state, which results in some annual versus quarterly processes.

Other items noted in the As-Is assessment were:

- DMAS uses the CMS MBES/CBES system to submit some reports
- This process utilizes many manual processes
- The overall accuracy of results is at 99%, but the MITA Framework is not totally adopted.

3.5.3.3.3 To-Be Assessment

DMAS intends to move the Manage Fund business process to a Level 3 rating.

Specific changes identified include:

- Identify opportunities for further automation of the process that provide cost-beneficial results
- Pursue increased collaboration and electronic information sharing to improve accuracy and effectiveness
- Identify and capture performance measures and use them to identify additional improvements.

3.5.3.3.4 Scorecard

The following scorecard was compiled for the Manage Fund business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payables Management Manage Fund	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	3	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		

Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		
Supporting Evidence Reference		

3.5.3.4 Generate Financial Report

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Generate Financial Report business process.

3.5.3.4.1 Business Process Model

The Generate Financial Report business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

FM Fiscal Management		
Generate Financial Report		
Item	**Details**	**DMAS Differences/Comments**
Description	It is essential for the State Medicaid Agency (SMA) to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the established benefits and programs are meeting the needs of the member population and are performing according to the intent of the legislative laws or federal reporting requirements. The ***Generate Financial Report*** business process begins with a request for information or a timetable for scheduled correspondence. The business process includes: • Defining the report attributes (e.g., format, content, frequency, media, and retention). • Defining the state and federal budget categories of service, eligibility codes, provider types, and specialties (taxonomy).	

FM Fiscal Management		
Generate Financial Report		
Item	**Details**	**DMAS Differences/Comments**
	• Extracting required financial information from source data stores. • Transforming information to meet business and technical needs of target destination. • Applying necessary encryption algorithms for security. • Sending alert with information to the target destination. **NOTE:** This business process does not include maintaining the benefits, reference, or program information. Maintenance of the health plan, health benefits, and reference information is in separate business processes.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Request to generate on-demand report on financial and/or program information. • Periodic timetable (e.g., daily, weekly, quarterly) is due for financial reporting.	Quarterly

Result	• The on-demand or scheduled generation of a financial report.
	• The financial and program analysis report set sent to the **Send Outbound Transaction**.
	• Generation of Centers for Medicare & Medicaid Services (CMS) specific reports such as the following:
	  o CHIP Program Budget Report (CMS-21B)
	  o Medicaid Program Budget Report (CMS-37)
	  o Quarterly CHIP Statement of	

FM Fiscal Management		
Generate Financial Report		
Item	**Details**	**DMAS Differences/Comments**
	Expenditures (CMS-21) o Quarterly Expense Report (CMS-64) • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request for generation of financial report. 2. Agency logs the request. 3. Define required report(s) format, content, frequency, media for the reports, and its retention period. 4. Define data elements necessary to produce the report (e.g., state and federal budget categories of service, eligibility codes, and taxonomy codes). 5. Extract required information from source data stores. 6. If applicable, transform information to meet business and technical needs of target destination. 7. If applicable, apply necessary encryption algorithms for security. 8. Agency logs the response. 9. If applicable, send the report to the **Send Outbound Transaction** for delivery to target destination. 10. **END:** Review financial report for analysis or distribution.	There are several sources (10+), including MMIS (both directly through ECM and generated through SAS),drug rebate vendor, CARS, and others

FM Fiscal Management		
Generate Financial Report		
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Financial data store including accounts receivable, accounts payable, Recovery Audit Contractor (RAC) recoveries, and budget information Claims data store including payment information Member data store including demographics information Provider data store including provider network information Reference data store including code set information	Data from other systems are also used (see comment above)
Predecessor	***Manage Budget Information*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Information***	
Successor	**Send Outbound Transaction** ***Manage Data***	
Constraints	The generation of financial and program analysis reports will adhere to state-specific or federal laws, regulations, and requirements. These rules will differ by state.	
Failures	• Information is unavailable to generate the report.	
Performance Measures	• Time to complete process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy of decisions • Consistency of decisions and disposition = __% • Error rate = __% or less	• CMS-37 and CMS-21B are due 45 days before start of quarter • CMS-64 and CMS-21 are due 30 days after the end of quarter 99% accuracy 100% consistency 1% error rate

FM Fiscal Management		
Generate Financial Report		
Item	Details	DMAS Differences/Comments
		The above measures are estimated based on our understanding of the actual results over time.

3.5.3.4.2 As-Is Assessment

The overall rating for the Generate Financial Report business process is '2.' The required reports are accurately produced, but the information comes from multiple systems and involves significant effort in preparing the data for the reports.

Other items noted in the As-Is assessment were:

- Data comes from more than ten different sources
- Information is shared with other intrastate agencies
- There is a high level of effort required to prepare the reports, which negatively impacts the cost effectiveness
- Changes in coding results in constant changes to the report preparation process, including making updates to reports, so effort cannot be expended to improve the process.

3.5.3.4.3 To-Be Assessment

DMAS intends to move the Generate Financial Report business process to a Level 3 rating.

Specific changes identified include:

- Identify opportunities to make this process more automated to improve timeliness and efficiency
- Pursue increased collaboration and electronic information sharing that could improve accuracy and effectiveness
- Identify and capture performance measures and use them to identify additional improvements.

3.5.3.4.4 Scorecard

The following scorecard was compiled for the Generate Financial Report business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM - Accounts Payables Management Generate Financial Report	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	1	2
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	1	3
Performance Measure		
Supporting Evidence Reference	.	
Effort to Perform; Efficiency	1	2
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.6 MEMBER MANAGEMENT

OVERVIEW

The Member Management business area is a collection of business processes involved in communications between the SMA and the prospective or enrolled member and actions that the agency takes on behalf of the member. This business area is responsible for managing the member data store,

coordinating communications with both prospective and current members, outreach to current and potential members, and dealing with member grievance and appeals issues.

Business Process Models (BPMs) and Business Capability Matrices (BCMs) were not defined in the MITA Framework 3.0 for the Member Management business area. DMAS conducted the assessment using the materials that were available from our 2010 self-assessment.

The Member Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.6-1.

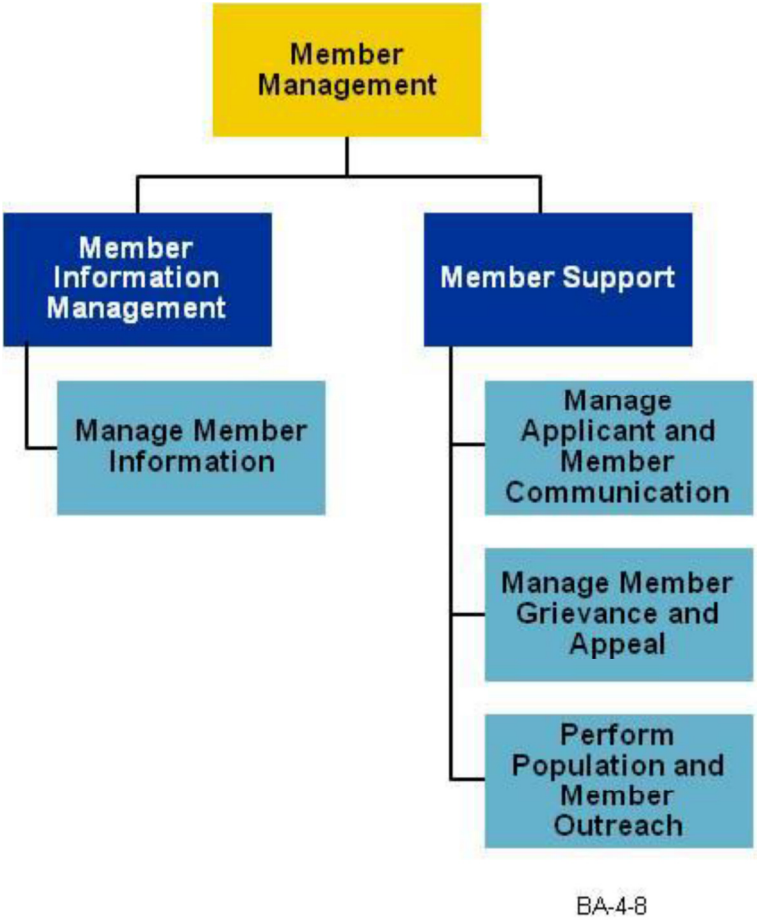


Figure 3.6-1

BUSINESS ARCHITECTURE PROFILE

The Member Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Member Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Manage Member Information		As-Is	To-Be		
Manage Applicant and Member Communication	As-Is		To-Be		
Manage Member Grievance and Appeal		As-Is	To-Be		
Perform Population and Member Outreach		As-Is	To-Be		

3.6.1 Member Information Management

As shown in Figure 3.6-1, the Member Information Management business category is made up of one business process:

- Manage Member Information

Details regarding the assessment of the Member Information Management business process follow.

3.6.1.1 Manage Member Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Member Information business process.

3.6.1.1.1 Business Process Model

The Manage Member Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

ME Member Information Management		
Manage Member Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Member Information*** business process is responsible for managing all operational aspects of the Member data store, which is the source of comprehensive information about applicants and	DMAS does not have a single "source of truth." Users must access multiple sources to obtain member information, such as VAMMIS, VaCMS, and local DSS

ME Member Information Management		
Manage Member Information		
Item	**Details**	**DMAS Differences/Comments**
	members, and their interactions with the state Medicaid. The Member data store is the Medicaid enterprise "source of truth" for member demographic, financial, socio-economic, and health status information. A member's data store record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services. In addition, the Member data store stores records about and tracks the processing of eligibility applications and determinations, program enrollment and disenrollment; the member's covered services, and all communications, e.g., outreach and EOBs, and interactions related to any grievance/appeal. The Member data store may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend- down information. Business processes that generate applicant or member information send requests to the Member data store to add, delete, or change this information in data store records. The Member data store validates data upload requests, applies instructions, and tracks activity. The Member data store provides access to member records, e.g., for Medicare Crossover claims processing and responses to queries, e.g., for eligibility verification, and "publish and subscribe" services for business processes that track member eligibility, e.g., ***Establish Case*** and ***Perform Applicant and Member***	office files. VAMMIS does not store any application or eligibility determination information. That is housed electronically within VaCMS and paper in the local DSS offices. Appeals information resides in the appeals data store.

ME Member Information Management		
Manage Member Information		
Item	**Details**	**DMAS Differences/Comments**
	Outreach.	

Trigger Event	• State transition trigger event: Receipt of request to add, delete, change Member information or pointers to member information records from
	  • Member Management Business Area processes: ***Determine Member Eligibility, Enroll and Disenroll Member***, ***Perform Applicant and Member Outreach, Manage Applicant and Member Communication,*** or ***Manage Member Grievance and Appeal***
	  • The Maintain Benefit/Reference Information process, which is the Member data store's source of benefit package information that may be changed during the member's enrollment span
	  • Operations Management Business Area processes: ***Process Claims, Process Encounters*** (e.g., claims/encounters, COB, TPL, member out-of-pocket co pay/coinsurance, HIPP, and service authorization), ***Calculate Spend-Down Amount***, or ***Process Member Premium Invoice***
	  • Care and Program Integrity Management Manage data store processes
	
	• Interaction-based Trigger Event: Receipt of a query about data in one or more applicant or member records from enterprise business processes, or from authorized external parties, e.g., for verification of member information.
	
	• Environmental Trigger Event: Scheduled transmission of member information records or pointers to member information on a periodic or real time basis to the Capitation and Premium Payment Area processes for	

ME Member Information Management		
Manage Member Information		
Item	**Details**	**DMAS Differences/Comments**
	payment preparation, and the Manage Program Information business process.	
Result	The Member data store is loaded with new or updated member information for the purposes of: 1. Responding to queries from authorized users and applications 2. Supplying all Member Management Area business processes with applicant or member information as needed to, e.g., detect duplicate applications; schedule redetermination; conduct open enrollment processing; perform member outreach and communication functions, etc. 3. Supplying all Operations Management Area business processes with applicant or member information needed to, e.g., edit claims and encounters, process member payment invoices, prepare EOB, conduct cost recoveries, etc. 4. Sending records or pointers to the Manage Program Information business process 5. Supplying all Care Management Area business processes with applicant or member information needed to e.g. create or update care plans. 6. Supplying data to Program Integrity business processes.	
Business Process Steps	1. **Start:** Receives data from Member Management Area and relevant Operations Management business processes 2. Loads data into the Member data store, building new records and updating, merging, unmerging, or deleting previous records as appropriate 3. Provides access to records as required by Member Management Area business processes workflow 4. Provides access to records as requested by	

ME Member Information Management		
Manage Member Information		
Item	**Details**	**DMAS Differences/Comments**
	other authorized business processes and users 5. Provides data to the ***Manage Performance Measures*** business process on a real time or periodic basis in update or snapshot mode 6. **End:** Archive data in accordance with state and federal record retention requirements	
Shared Data	The **Manage Member Information** business process accesses Shared Data needed to record information about the following: Member demographic, financial, socio-economic, and health status data; information related to requests for and determinations of eligibility, appointment scheduling, eligibility verification, and communications concerning outreach and education, programs, eligibility, enrollment, services, access, etc.; services requested and services provided; member payment and spend- down information; as well as interactions related to any grievance/appeal, data necessary for care management business processes.	Member ID is used to access a variety of information, including service authorization, claims, appeals, etc., by authorized users.
Predecessor	Inbound Transaction Processing for eligibility and enrollment applications, communications, scheduling requests. Member Management business processes supplying data to the Member data store, including ***Determine Member Eligibility****,* ***Enroll Member, Disenroll Member, Perform Population and Member Outreach, Manage Applicant and Member Communication,*** and ***Manage Member Grievance and Appeal.*** Operations Management business processes supplying data to the Member data store e.g., ***Calculate Spend-Down Amount*** *and* ***Prepare Member Premium Invoice*** business	

ME Member Information Management		
Manage Member Information		
Item	**Details**	**DMAS Differences/Comments**
	processes. Care Management business processes supplying data to the Member data store, e.g., ***Authorize Treatment Plan***	
Successor	There are two types of Successor Business Processes: a) those that are the director successor, i.e., the Result of Manage Member Information is a Trigger for another business process, and b) those that are indirect successors business processes that are consumers of Member information as Shared Data. <u>Direct Successor Business Processes</u> 1. Member Management – ***Enroll Member, Disenroll Member*** 2. Care Management – ***Establish Case*** 3. Program Integrity – ***Identify Compliance Incident*** <u>Indirect Successor Business Processes</u> Many business processes are dependent on current and accurate member information. These processes access the Member data store. *1.* Member Management business processes accessing data in the Member data store, including ***Determine Member Eligibility***, ***Perform Population and Member Outreach***, ***Manage Applicant and Member Communication***, and ***Manage Member Grievance and Appeal***. 2. Operations Management Area business processes, including: ***Process Claims***, ***Process Encounters***, ***Prepare Health Insurance Premium Payment***,	

ME Member Information Management		
Manage Member Information		
Item	**Details**	**DMAS Differences/Comments**
	Prepare Medicare Premium Payment and ***Manage Capitation Payment*** business processes; ***Process Member Premium Invoice***, ***Prepare EOB***, and ***Calculate Spend-Down Amount*** business processes; and all Cost Recovery business processes. 3. Care Management Business Area: ***Establish Case*** business processes. 4. ***Manage Program Information*** business process. 5. Program Integrity ***Establish Compliance Incident*** business processes.	
Constraints	State specific work flows will determine which processes load and access the Member data store and by which interactions and messages (e.g., query/response, batch uploads, publish and subscribe, etc.); and the data content and structure of data store records.	
Failures	Member data store fails to load or update appropriately; or fails to make data store data available or available in correct format.	
Performance Measures	1. Time to update member data set: e.g., Real Time response = within seconds, Batch Response = within hours 2. Response Accuracy = % 3. Error rate = % or less	DMAS has some performance measures but they vary by program. VAMMIS processes follow contractual SLAs.

3.6.1.1.2 As-Is Assessment

The overall rating for the Manage Member Information business process is '2.' DMAS has some rule-based validation and automated data reconciliation processes that support Manage Member Information. Automated maintenance of member information ensures that timely, accurate data are available to support all processes needing member information, e.g., MCO enrollment rosters, COB, adjudication, etc. However, numerous data entry staff are required to key new and updated information and reconcile duplicates and other data inconsistencies.

DMAS does not have a single "source of truth." Users must access multiple sources to obtain member information, such as VAMMIS, VaCMS, and local DSS office files.

Other items noted in the As-Is assessment were:

- Automated updates are made to files and relational databases but there are recurring problems with data issues, such as duplicate identifiers and discrepancies between data stores
- Key DSS data cannot be updates through VAMMIS
- IT staff must be used to load member information generated from other systems.

3.6.1.1.3 To-Be Assessment

DMAS intends to achieve Level 3 for the Determine Member Eligibility business process.

Specific objectives include:

- Migration toward completion of the Enrollment and Eligibility Project and the sunset of legacy systems
- Increased online verification
- Reduction of manual intervention
- Direct access to data
- Focus of manual efforts on exceptions.

These improvements should result in an increase in member and provider satisfaction, increased electronic communication leading toward the overall enhancement of business capability levels.

In the absence of a current business capability matrix, we have based our assessment on a general understanding of the MITA expectations. We will re-evaluate once specific measures are defined.

3.6.1.1.4 Scorecard

The following scorecard was compiled for the Manage Member Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
ME - Member Information Management ***Manage Member Information***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	1	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	1	2
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	1	2
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.6.2 Member Support

As shown in Figure 3.6-1, the Member Support business category is made up of three business processes:

- Manage Applicant and Member Communication
- Manage Member Grievance and Appeal
- Perform Population and Member Outreach.

Details regarding the assessment of each Member Support business process follow.

3.6.2.1 Manage Applicant and Member Communication

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Applicant and Member Communication business process.

3.6.2.1.1 Business Process Model

The Manage Applicant and Member Communication business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

ME Member Support		
	Manage Applicant and Member Communication	
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Applicant and Member Communication*** business process receives requests for information, appointments, and assistance from prospective and current members' communications such as inquiries related to eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and produced for distribution via ***Send Outbound Transaction*** process. **NOTE:** Inquires from applicants, prospective and current members are handled by the	Several help lines are available, including: • DMAS FFS recipient • DMAS MCO and MMP enrollment broker • Service Authorization vendor • Cover Virginia • DSS • MCO, MMP, and ASO contractors. VDSS CommonHelp customer portal is available to the public for filing applications, reporting changes, and other functions. Electronic notifications are not currently

ME Member Support		
	Manage Applicant and Member Communication	
Item	**Details**	**DMAS Differences/Comments**
	Manage Applicant and Member Communication process by providing assistance and responses to *individuals*, i.e., bi-directional communication. Also included are scheduled communications such as Member ID cards, redetermination notifications, or formal program notifications such as the dispositions of grievances and appeals. The *Perform Applicant and Member Outreach* process targets both prospective and current Member *populations* for distribution of information about programs, policies, and health issues.	available.
Trigger Event	Interaction-based Trigger Events: – Inquiry from current or prospective member. – Request to send information packages such as eligibility applications and health plan open enrollment forms. – Request to schedule an appointment to determine eligibility. – Request for assistance, such as a request to change PCCM, health plan, or lock-in provider. – Requests from other processes to develop and produce communications for members such as notifications from the ***Determine Member Eligibility*** process, requests for additional information, new eligible information packages, or determination decisions. – Includes inquiries originating from customer help desk Event-based Trigger Events: – Scheduled time to send information, e.g., redetermination notification, and monthly communications such as enrollment cards. - Follow-up on requests from grievances	

ME Member Support		
	Manage Applicant and Member Communication	
Item	**Details**	**DMAS Differences/Comments**
Result	1. Member receives appropriate assistance, communications, appointment and/or information packages. 2. Tracking information regarding the interchange as needed for the ***Manage Applicant and Member Communication*** process and the **Monitor Performance** Business Activity process to ensure that applicants and members receive the information they need.	
Business Process Steps	1. Start: Receive request for communication from **Receive Inbound Transaction** process or from other processes such as ***Determine Member Eligibility*** or ***Manage Member Grievance and Appeal*** to prepare communications 2. Log and track communications request and response processing data 3. Research/develop communication that is linguistically, culturally, and competency appropriate 4. Prepare/package communication 5. Perform Review or Quality Check communication 6. End: Send member communications and information packages to be distributed by the **Send Outbound Transaction** process. [**NOTE:** May simply route inbound messages to other processes without creating outbound.]	#2 DMAS doesn't have a central tracking mechanism for communication requests. #3 DMAS makes an effort to do this but it's not always consistent. #5 DMAS spot checks communication but the process could be inconsistent.
Shared Data	• Benefit Data store: Services and provider types covered; program policy; and health plan contractor information • Member Data store: Member demographics, benefit package, eligibility/enrollment data; applicant/member financial, social,	

ME Member Support		
	Manage Applicant and Member Communication	
Item	**Details**	**DMAS Differences/Comments**
	functional and clinical data. Updated enrollment data is loaded • Contractor Data store: Contracted service areas, MCO provider network and other provider data • Provider Data store: Provider data, such as type, location, availability, gender and linguistic and cultural competence • Service Directories such as Claims History, Prior Authorization, and Care Planning • Ancillary Communication Tracking Systems: Customer Relationship Management (CRM), Help Desk Log, PHI disclosure log, etc.	
Predecessor	**Receive Inbound Transaction** ***Determine Member Eligibility*** ***Manage Member Grievance and Appeal*** ***Perform Population and Member Outreach***	
Successor	**Send Outbound Transaction**	
Constraints	Communications requested will vary depending on programs supported by the agency, e.g., managed care, waiver, PCCM and lock-in programs require provider assignment which members may request to change. If eligibility is determined outside the agency, then this process may not be requested to send applications or schedule eligibility determination appointments.	
Failures	1. Inability to provide linguistically, culturally, or competency appropriate information 2. Communication barriers such as lack of internet or phone access connectivity or unavailability of system; failure to access needed or requested information. This failure may occur on either the member or	

ME Member Support		
	Manage Applicant and Member Communication	
Item	**Details**	**DMAS Differences/Comments**
	State side of the process. 3. Delivery failures due to erroneous contact information or lack of contact information for mobile communities such as migrant workers or the homeless population. 4. Member does not respond to communication	
Performance Measures	Examples of Measures – 1. Time to complete process of developing communications: By phone minutes; by email hours; by mail __days 2. Accuracy of communications = % 3. Successful delivery rate to targeted individuals = %	DMAS has performance measures but they vary by business entity. Since DMAS doesn't have a central logging system, performance measures are difficult to track. DMAS contractors are required to maintain DMAS-defined performance measures.

3.6.2.1.2 As-Is Assessment

The overall rating for the Manage Applicant and Member Communication business process is '1.' Virginia is at Level 1 with some aspects of Levels 2 & 3. Delivery obstacles may be encountered, e.g. incorrect or lack of information. Requests are currently received from members in non-standard formats. Most requests are sent via telephone, fax, or USPS. Research is performed manually. Responses are inconsistent and manual.

Other items noted in the As-Is assessment were:

- Electronic access by applicants/members is currently limited to information available through VaCMS
- Research staff is required to manually respond to specific requests
- Responses are manually validated, e.g., call center audits
- Members receive the information they need but with some response delay.

3.6.2.1.3 To-Be Assessment

DMAS intends to achieve an overall Level 2 for the Manage Applicant and Member Communication business process and move to Level 3 for some capabilities.

Specific objectives include:

- Migration toward completion of the Enrollment and Eligibility Project
- Continuation of no wrong door access
- Expansion of contracts to include electronic messaging
- Refined contractor performance.

In the absence of a current business capability matrix, we have based our assessment on a general understanding of the MITA expectations. We will re-evaluate once specific measures are defined.

3.6.2.1.4 Scorecard

The following scorecard was compiled for the Manage Applicant and Member Communication business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
ME - Member Support ***Manage Applicant and Member Communication***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	1	2
Timeliness of Process	1	2
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	1	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	1	2
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	1	2
Performance Measure		
Supporting Evidence Reference		

Accuracy of Process Results	1	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	1	3
Performance Measure		
Supporting Evidence Reference		

3.6.2.2 Manage Member Grievance and Appeal

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Member Grievance and Appeal business process.

3.6.2.2.1 Business Process Model

The Manage Member Grievance and Appeal business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

ME Member Support		
Manage Member Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Member Grievance and Appeal*** business process handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the ***Manage Applicant and Member Communication*** process via the **Receive Inbound Transaction** process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of	The Appeals Division handles appeals of adverse actions. Appeals are submitted directly by the applicant/member or their representative. Grievances/complaints are handled by internal divisions such as operations and policy; and other entities such as MCOs, ASOs, and other contractors and vendors.

ME Member Support		
Manage Member Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
	the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file. The applicant or member is formally notified of the decision via the ***Send Outbound Transaction*** Process. This process supports the ***Manage Performance Measures*** Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. In some states, if the applicant or member does not agree with the Agency's disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or member is urgent, the appeal may be expedited. **NOTE:** States may define "grievance" and "appeal" differently, perhaps because of state laws. States must enforce the Balance Budget Act requirements for grievance and appeals processes in their MCO contracts at 42 CFR Part 438.400. They may adopt these for non-MCO programs.	The SMA conducts a State Fair Hearing and issues a decision that may be appealed in circuit court. DMAS handles appeals for the Fee For Service and Managed Care program. MCOs and ASOs have their own internal grievance process, and an appeal process that is available to applicants/members. With limited exceptions, MCO and ASO applicants/members may file an appeal with DMAS before, during, or after they file an appeal with the MCO or ASO. DMAS allows appeals to be expedited if they meet certain criteria. The Managed Care Program supports the Program Quality Management process by including monitoring of enrollee grievances and appeals in the MCOs Quality Improvement Program (QIP).
Trigger Event	Receipt of grievance or appeal of adverse decision data set from **Receive Inbound Transaction** process.	Receipt of an appeal of an adverse action from an applicant/member or their representative.
Result	Final disposition of grievance or appeal sent to the applicant or member via the **Send Outbound Transaction** process.	Appeal only.

ME Member Support		
Manage Member Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
Business Process Steps	7. **Start:** Receive grievance or appeal via **Receive Inbound Transaction** Process 8. Request additional documentation if needed 9. Determine status as initial, second, or expedited. 10. Triage to appropriate personnel for evaluation. 11. Schedule review or hearing within required time. 12. Conduct review or hearing within required time. 13. Determine disposition. 14. **End:** Request that the ***Manage Applicant and Member Communication*** process prepare a formal disposition to be sent to the applicant or member via **Send Outbound Transaction** process.	Appeal only 'Second' refers to appeal to circuit court. Appeal requests are filed by postal mail, email and faxes. The process is highly manual although some functions are automated (e.g., generation of notices from the system). Document management is presently handled by scans and emails, which makes cases widely available to users with appropriate security access and saves time. Verifications in some cases are done electronically.
Shared Data	1. Benefit data store: Services and provider types covered; program policy; and health plan contractor information 2. Member data store: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. 3. Contractor data store: Contracted service areas, MCO provider network and other provider data 4. Provider data store: Provider data, such as type, location, availability, gender and linguistic and cultural competence 5. Policy data store: Based on the appeal process, if a member wins an appeal that could impact or clarify a policy, that information would be shared to a process that would change or modify policy and/or the state plan.	
Predecessor	Receipt of grievance or appeal data set from **Receive Inbound Transaction** process.	Appeal only
Successor	Formally notify applicant or member via **Send Outbound Transaction**	

ME Member Support		
Manage Member Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
	process.	
Constraints	In addition to general rights of Medicaid and Medicare beneficiaries under federal law, state policy and state law constrain the legal issues about which applicants and members may file grievances and appeals, provide additional rights, e.g., for second or expedited appeal, and set time limits for disposing of the appeal.	
Failures	Applicant, member, or representative causes cessation of grievance/appeal.	Administrative cessation of the appeals process is within the confines of State and Federal laws.
Performance Measures	Examples of Measures – 1. Time to complete process: standard grievance/appeal = __days; second appeal = days; expedited appeal = hours 2. Accuracy of decisions = % 3. Consistency of decisions and disposition = _____%	Performance measures are to meet the stated time deadlines. Time to complete standard appeals - 90 days Second appeal – N/A to SMA, goes to circuit court Time to complete expedited appeals varies based on the type of appeal from 72 hours to 21 days. Accuracy and Consistency of decisions are expected to be 100%.

3.6.2.2.2 As-Is Assessment

The overall rating for the Manage Member Grievance and Appeal business process is '2.' The processes are performed in compliance with State Fair Hearing regulations. While many activities are performed manually, productivity greatly improved when access to systems like VACMS and Enterprise Content Manager was granted. Staff can efficiently research and retrieve key documents and other case information electronically for greater than 50% of the cases. Several initiatives are underway to implement additional electronic processes that will completely overhaul the current processes.

Other items noted in the As-Is assessment were:

- The duration of end-to-end process is 90 calendar days or longer; applicant/member response to requests can take 10 calendar days or longer
- Access to VACMS to gather information about cases as well as use of ECM (documentation management system) to access system generated notices improve accuracy; case information exceeds 98% accuracy
- Greater use of email and access to shared drives, VaCMS, and ECM reduce costs
- There is still a high dependence on manual processes, but increased productivity has resulted from the use of ECM to access system notices, the use of Outlook and other electronic calendars for some scheduling, Oracle to track appeal status, and the MMIS and VACMS to verify case status; research of codes and policy is performed electronically over the Internet
- Online training and electronic manuals as well as electronic research of case law, codes and policy improve accuracy of results. Access to prior appeal decisions with similar issues on a shared drive improves accuracy of results; the low percentage of cases overturned at the Circuit Court level is evidence of accuracy (accuracy is greater than 95%)
- While the process is lengthy, and many activities are performed manually, the end result is of high value and there are very minimal expressions of dissatisfaction from contractors and other Stakeholders; to mitigate concerns about the time it takes to reach a resolution, the unit recently implemented a new process, which is to acknowledge receipt of every appeal - it is a manual process, but will be automated by way of a confirmation message with e-filing.

3.6.2.2.3 To-Be Assessment

Several capabilities of the Manage Member Grievance and Appeal business process will reach Level 3 in the near future. DMAS intends to achieve an overall Level 3 for this business process within the next year and a half.

Specific changes identified include:

- Identify opportunities to make this process more automated to improve timeliness and efficiency; a planned DMAS-developed e-filing system should be available within the next six months; e-filing capability will result in reduction of time and greater processing efficiency
- Pursue increased standardization and sharing of information sharing that could improve accuracy and effectiveness; DMAS is actively engaged in design and development of test scenarios for automation of appeals in Phase II VACMS; testing will begin in September 2015 and completion of Phase II will result in total automation of the appeals process
- After implementation of e-filing, less staff will be needed to handle the volume of incoming appeals, and existing support staff can be retrained to handle other steps in the process to improve cost-effectiveness
- Identify and capture performance measures and use them to identify additional improvements.

In the absence of a current business capability matrix, we have based our assessment on a general understanding of the MITA expectations. We will re-evaluate once specific measures are defined.

3.6.2.2.4 Scorecard

The following scorecard was compiled for the Manage Member Grievance and Appeal business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
ME - Member Support ***Manage Member Grievance and Appeal***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	1	2
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	1	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.6.2.3 Perform Population and Member Outreach

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Perform Population and Member Outreach business process.

3.6.2.3.1 Business Process Model

The Perform Population and Member Outreach business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

ME Member Support		
	Perform Population and Member Outreach	
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Perform Population and Member Outreach*** business process originates internally within the Agency for purposes such as: • Notifying prospective applicants and current members about new benefit packages and population health initiatives • New initiatives from Program Administration • Receiving indicators on underserved populations from the ***Monitor Performance and Business Activity*** process (Program Management) It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children's Health Insurance Program (SCHIP). Outreach information is developed for targeted	Outreach has been typically limited to FAMIS (SCHIP). Outreach has recently been initiated due to grant received through ACA. However, outreach is normally accomplished through stakeholders, such as advocates and local DSS offices. MCOs, MMPs, and ASOs (DMAS contractors) conduct some population and member outreach. This paragraph does not apply to our outreach.

ME Member Support		
	Perform Population and Member Outreach	
Item	**Details**	**DMAS Differences/Comments**
	populations that have been identified by analyzing member data. Outreach communications and information packages are distributed accordingly through various mediums via the **Send Outbound Transaction** and the ***Manage Business Relationship Communication*** processes. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the **Monitor Performance and Business Activity** process. **NOTE:** The ***Perform Population and Member Outreach*** process targets both prospective and current Member *populations* for distribution of information about programs, policies, and health issues. Inquiries from applicants, prospective and current members are handled by the ***Manage Applicant and Member Communication*** process by providing assistance and responses to *individuals*, i.e., bi-directional communication.	
Trigger Event	State-transition Trigger Events: • Implementation of population health initiatives such as ESPDT and enrollment campaigns for SCHIP • Scheduled communications related to current programs such as open enrollment • Changes to existing plans or benefit packages • Call center volumes exceed a threshold on a particular issue • New program policies and procedures • Changes to existing policies and	

ME Member Support		
	Perform Population and Member Outreach	
Item	**Details**	**DMAS Differences/Comments**
	procedures • Critical need in a specific targeted population • Identification of underserved and currently served populations in need of services or access • Other healthcare or Federal mandates (e.g., Privacy notice)	
Result	Outreach communications, such as mailings brochures, web pages, e-mail, kiosk, and radio, billboard, and TV advertisements; are produced and distributed to targeted populations or individuals.	
Business Process Steps	1. **Start**: Population is identified and defined by analyzing member service data, performance measures, feedback from community, and policy directives 2. Receive request for outreach materials or communications 3. Approve or deny (or modify) decisions to develop outreach communications 4. Determine development approach (internal and external or both) outreach materials, approaches, success measures 5. Approval of outreach materials 6. Distribute outreach materials or communications through various media supported by the **Send Outbound Transaction*, Manage Applicant and Member Communication***, or the ***Manage Business Relationship Communications*** process (to be distributed to targeted populations by community resource and advocacy groups, providers, and other entities that work with the targeted population) 7. Outreach communications production and distribution are tracked and materials archived [Steps may differ in a State-wide managed	.

ME Member Support		
	Perform Population and Member Outreach	
Item	**Details**	**DMAS Differences/Comments**
	care setting.]	
Shared Data	• Care Management population health data • Program Quality Management quality measure data, e.g., CAPHS and HEDIS measures • Benefit data store: Services and provider types covered; program policy; and health plan contractor information • Member data store: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded • Contractor data store: Contracted service areas, MCO provider network and other provider data • Provider data store: Provider data, such as type, location, availability, gender, linguistic qualifications and cultural competence. • Claims history	
Predecessor	Care Management, Benefit Administration, Program Administration, or Program Quality Management processes result in need to perform outreach to prospective members	
Successor	• **Send Outbound Transaction**, ***Manage Applicant and Member Communication*** and/or ***Manage Business Relationship Communication*** processes distribute communications to the targeted population • **Monitor Performance and Business Activity Process** measures Outreach efficacy	
Constraints	Communications and information packages must address the needs of the targeted population. Materials must be linguistically and culturally appropriate, legally compliant,	

ME Member Support		
	Perform Population and Member Outreach	
Item	**Details**	**DMAS Differences/Comments**
	appropriate to the targeted group, meet financial guidelines (re: cost to produce and distribute). Other constraints may be agency priority, availability of resources, and accuracy of member contact information.	
Failures	1. Inability to produce information that is useable due to language, culture, or reading comprehension barriers 2. Communication barriers such as lack of internet or phone access; failure to access needed or requested information 3. Delivery failures due to erroneous contact information or lack of contact information for mobile communities such as migrant workers or the homeless population	
Performance Measures	Examples of Measures – 4. Time to complete process of developing outreach materials from receipt of request to completion of distribution = days 5. Accuracy of outreach materials = % 6. Successful delivery rate to targeted individuals = ___% 7. Combination of staff plus automated processes results in utilization of ____ FTEs per occurrence of this process.	Any performance measures would be determined by the specific outreach effort.

3.6.2.3.2 As-Is Assessment

The overall rating for the Perform Population and Member Outreach business process is '2.' Population and member outreach has historically been limited to FAMIS (CHIP), and in general is only addressed when there is specific funding to perform. The process has many capabilities that are consistent with Level 2, such as use of a web portal and media advertisements and targeted outreach efforts. Materials can be posted on a Web site for downloading by members. There are sometimes delivery issues due to

the lack of contact information.

Other items noted in the As-Is assessment were:

- Electronic storage and dissemination of member materials shortens the time to reach the members; fewer staff required to support but paper and non-routine outreach is still time-consuming
- Access to electronic sources or outreach and education materials somewhat reduces time that current and prospective members must spend discovering needed information as well as mailing costs; current and prospective members can access needed information via Web portal
- It is difficult to determine impact of outreach and education; current and prospective members continue to need assistance by phone
- Populations are targeted more effectively because programs are able to share analysis of data and results
- The members and the agency benefit from introduction of automation to speed up the outreach and education process.

3.6.2.3.3 To-Be Assessment

DMAS intends to achieve Level 3 for the Perform Population and Member Outreach business process. Potential development of intrastate information exchange hubs may assist in development of this area.

Other specific changes identified include:

- Identify opportunities to make this process more automated to improve timeliness and efficiency
- Pursue increased standardization and sharing of information sharing that could improve accuracy and effectiveness
- Identify and capture performance measures and use them to identify additional improvements.

In the absence of a current business capability matrix, we have based our assessment on a general understanding of the MITA expectations. We will re-evaluate once specific measures are defined.

3.6.2.3.4 Scorecard

The following scorecard was compiled for the Perform Population and Member Outreach business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
ME - Member Support ***Perform Population and Member Outreach***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3

Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	1	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.7 OPERATIONS MANAGEMENT

OVERVIEW

The Operations Management business area is a collection of business processes that manage claims and prepare provider payments. This business area uses a specific set of claims-related data and includes processing (i.e., editing, auditing and pricing) a variety of claim forms including professional, dental, institutional, drug and encounters, as well as sending payment information to the provider. All claim processing activity incorporates compatible methodologies of the National Correct Coding Initiative (NCCI). The Operations Management business area is responsible for the claims data store.

The Operations Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.7-1. Although the Claims Adjudication business category in the MITA 3.0 Framework includes Calculate Spend-Down Amount and Submit Electronic Attachment, these business processes are not performed by the Virginia Medicaid agency.

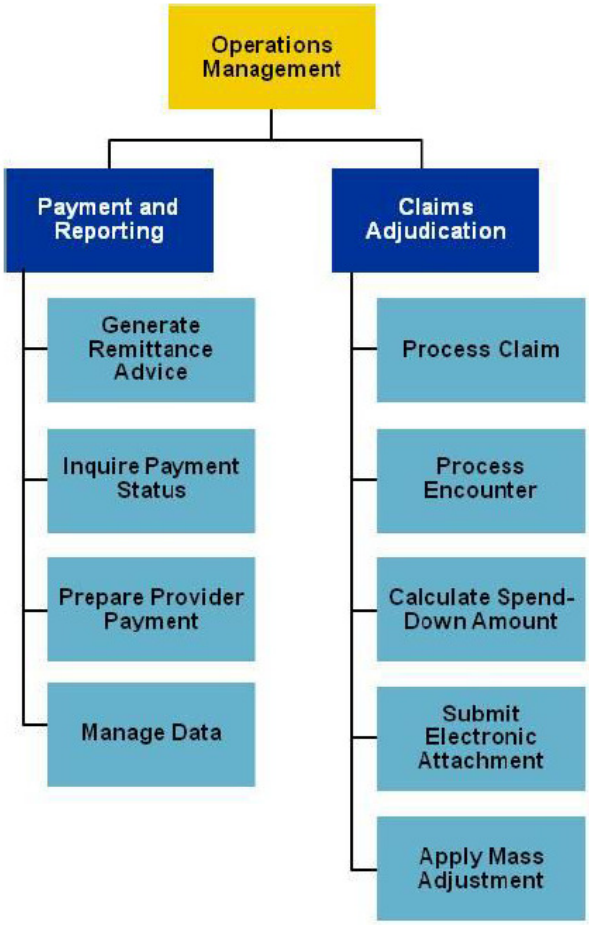


Figure 3.7-1

BUSINESS ARCHITECTURE PROFILE

The Operations Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Operations Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Generate Remittance Advices		As-Is	To-Be		
Inquire Payment Status		As-Is	To-Be		
Prepare Provider Payment		As-Is	To-Be		
Manage Data		As-Is	To-Be		
Process Claims		As-Is	To-Be		
Process Encounters		As-Is	To-Be		
Calculate Spend-Down Amount	NA				
Submit Electronic Attachment	NA				
Apply Mass Adjustment		As-Is	To-Be		

3.7.1 Payment and Reporting

As shown in Figure 3.7-1, the Payment and Reporting business category is made up of 4 business processes:

- Generate Remittance Advices
- Inquire Payment Status
- Prepare Provider Payment
- Manage Data

Details regarding the assessment of each Payment and Reporting business process follow.

3.7.1.1 Generate Remittance Advices

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Generate Remittance Advices business process.

3.7.1.1.1 Business Process Model

The Generate Remittance Advices business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

OM Payment and Reporting		
Generate Remittance Advice		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Generate Remittance Advice*** business process describes the activity of preparing remittance advice/encounter Electronic Data Interchange (EDI) transactions that providers use to reconcile their accounts receivables. This business process begins with receipt of information resulting from the ***Process Claim*** business process, performing required manipulation according to business rules and formatting the results into the required output information that process sends to **Send Outbound Transaction**.	We do not prepare a remittance advice for Managed Care Encounters. We send the Managed Care plans a proprietary report that shows the results of processing the encounter claims in the MMIS.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive the claims information from the ***Process Claim*** business process.	
Result	• Alert to send to provider Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice transaction. • Tracking information as needed for measuring performance and business activity monitoring.	Approximately 90% of providers are receiving 835s. We also send out paper remittances to providers who indicate that they still want paper remits. We mail remittances to the providers who indicate that they want paper and also store their remittances on the portal. All remittances are available in our ECM.
Business Process	1. **START:** Receive claims information from the ***Process Claim*** business process.	

OM Payment and Reporting		
Generate Remittance Advice		
Item	**Details**	**DMAS Differences/Comments**
Steps	2. Perform required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, e.g., bundling or unbundling of services. 3. Generate remittance advice transaction. 4. Send alert to send to provider ASC X12 835 Health Care Claim Payment/Remittance Advice transactions. 5. **END:** If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA).	We don't get a 997 in all cases, but when we do, we respond with a 999. We do not use the 824 transaction.
Shared Data	Provider data store including provider network and contract information Claims data store including payment information	
Predecessor	***Process Claim***	
Successor	**Send Outbound Transaction** ***Manage Data***	
Constraints	Remittance Advice-Encounter Reports conforms to the format and content in accordance with federal and state-specific reporting requirements, e.g., using HIPAA Transaction Standard Companion Guide that may differ based on situational fields determined by state policy.	

OM Payment and Reporting		
Generate Remittance Advice		
Item	**Details**	**DMAS Differences/Comments**
Failures	• Unresolved conflicts in the reported details in the remittance advice.	We have no unresolved conflicts. This is not applicable to Virginia.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___ seconds, Batch Response = within ___hours • Accuracy with which remittance advice/encounter report rules are applied = _____% • Error rate = ___% or less	Time to Complete: No real-time 835s Must have the 835s issued within 48 hours of the weekly process, consistent with CORE standards. Accuracy = 100% Error Rate = 0%

3.7.1.1.2 As-Is Assessment

The overall rating for the Generate Remittance Advices business process is '2.' The business process steps followed at DMAS are very similar to the MITA 3.0 framework in most cases. We are compliant with HIPAA 5010 and CORE standards. Overall quality and accuracy is considered to be excellent.

Other items noted in the As-Is assessment were:

- Several capability questions in the Business Process would have been a Level 3 if the term 'agencies ***and*** entities' were considered to mean 'agencies ***or*** entities'.
- Managed Care plans receive a proprietary report that shows the results of processing the encounter claims in the MMIS rather than an 835.
- Approximately 90% of Fee for Service providers are receiving 835s.
- Some providers continue to request paper Remittance Advices in addition to or instead of an 835.
- DMAS does not generate real-time 835s.

3.7.1.1.3 To-Be Assessment

DMAS intends to achieve Level 3 functionality with regards to the Generate Remittance Advices business process.

Specific changes include:

- Further reduce or eliminate paper Remittance Advices and incorporate nationally recognized standards for this exchange of information
- Explore collaboration and electronic information sharing with other agencies and entities
- Identify and capture performance measures and use them to identify additional improvements.

3.7.1.1.4 Scorecard

The following scorecard was compiled for the Generate Remittance Advices business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
FM Accounts Payables Management Generate Remittance Advice	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		

Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.7.1.2 Inquire Payment Status

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Inquire Payment Status business process.

3.7.1.2.1 Business Process Model

The Inquire Payment Status business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

OM Payment and Reporting		
Inquire Payment Status		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Inquire Payment Status*** business process begins with receiving an Accredited Standards Committee (ASC) X12 276 Health Care Claim Status Request transaction or a request for information received through other means such as email, paper, telephone, facsimile, web, or Automated Voice Response (AVR). The business process handles the request for the status of a specified claim(s), retrieves information from the claims payment history, and generates the response information. In addition, the business process formats the information into the ASC X12 277 Health Care Information Status Notification transaction, or other mechanism for responding, via the media used to communicate the inquiry, and sends claim status response via the **Send Outbound Transaction**.	DMAS does not email, paper, facsimile. We support batch 276, web, AVR, phone to help desk.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive status request via ASC X12 276 Health Care Claim Status Request transaction. Environment-based Trigger Events to include but not limited to:	

OM Payment and Reporting		
Inquire Payment Status		
Item	**Details**	**DMAS Differences/Comments**
	• Receive status request via email, mail, mobile device, facsimile, telephone, or web.	
Result	• Requester received claims status information. • If applicable, response sent via ASC X12 277 Health Care Information Status Notification transactions to requester. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Tracking information as needed for measuring performance and business activity monitoring.	DMAS does not use the 824 transactions or the 276 real-time transaction. X12 Transactions processes for SMA related to ***Inquire Payment Status are***: 276, 277, 997, and 999.
Business Process Steps	1. **START:** Receive claim status request. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process ends. 2. Agency logs claim status request. 3. Validate requester has authorization to receive requested information. 4. Inquire the payment status information to obtain required requested data elements (e.g., member birth date, member last and first name, member ID, claim service date, internal	The VA 276/277 Transactions EDI Companion Guide describes the processes and elements needed to submit the 276 to DMAS. #4. We allow Billing Provider NPI, Servicing Provider NPI, ICN, Service from Date, Service Thru Date, Claim Status (Approved, Denied, Pended, etc.), and Member ID

OM Payment and Reporting		
Inquire Payment Status		
Item	**Details**	**DMAS Differences/Comments**
	control number, medical record number). 5. Generate claim status response. 6. If applicable, provide claim status response via ASC X12 277 Health Care Information Status Notification transactions to requester. 7. **END:** If applicable, receive alert from submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA).	
Shared Data	Claim data store including payment information	
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter*** ***Generate Remittance*** ***Advice Apply Mass Adjustment***	Process Encounter not applicable. We do not return status information on Encounters.
Successor	**Send Outbound Transaction**	
Constraints	Payment Status Inquiry and Response will conform to the format and content in accordance with federal and state-specific requirements, e.g., using HIPAA Transaction Standard Companion Guide that may differ based on situational fields determined by state policy.	
	• The State Medicaid Agency (SMA) does	Additional Failure: If we receive a

OM Payment and Reporting		
Inquire Payment Status		
Item	**Details**	**DMAS Differences/Comments**
Failures	not receive the claim Payment Status Inquiry submission.	request that cannot be processed due to missing or incorrect information.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___ seconds, Batch Response = within ___hours • Accuracy with which payment status rules are applied = __% • Consistency with which payment status rules are applied = __% • Error rate = ___% or less	Online response times are within 2 minutes based on current SLA. Batch Response = 15 hours Accuracy: 100% Consistency: 100% Error Rate: 0 %

3.7.1.2.2 As-Is Assessment

The overall rating for the Inquire Payment Status business process is '2.' The Business Capability questions related to Manual vs. Automated Process and Integration were rated at Level 3. Access was rated as Level 2, however it was approaching a Level 3 based on the fact that the system data is accessible to intrastate entities and there is only a single source system, as opposed to disparate systems.

Other items noted in the As-Is assessment were:

- Several capability questions in the Business Process would have been a Level 3 if the term 'agencies ***and*** entities' were considered to mean 'agencies ***or*** entities'.
- At DMAS, the Inquire Payment Status business process does not involve e-mail, paper or facsimile, however it does include batch 276 transactions, a provider web portal, AVR, and phone access to the DMAS help desk.
- The 824 transactions and 276 real-time transactions are not used at DMAS.
- Online inquiries are completed within 2 minutes and batch inquiries are completed within 15 hours.

3.7.1.2.3 To-Be Assessment

DMAS intends to achieve Level 3 functionality for the Inquire Payment Status business process.

Specific changes include:

- Standardize real time transactions by incorporating any additional nationally recognized standards for exchange of information that would be helpful to providers.
- Collaborate with other intrastate agencies to adopt national standards and look for cost-effective opportunities to develop and share reusable business services for payment status.
- Investigate the use of regional information exchange hubs
- Identify and capture performance measures and use them to identify additional improvements.

3.7.1.2.4 Scorecard

The following scorecard was compiled for the Inquire Payment Status business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
Operations Management Inquire Payment Status	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		

Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.7.1.3 Prepare Provider Payment

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Prepare Provider Payment business process.

3.7.1.3.1 Business Process Model

The Prepare Provider Payment business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

OM Payment and Reporting		
Prepare Provider Payment		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Prepare Provider Payment*** business process is responsible for the preparation of the payment report information. Reports sent via email, mail, or Electronic Data Interchange (EDI) to providers and used to reconcile their accounts receivable. Many Home and Community-Based Services (HCBS) are not part of the traditional Medicaid health plan. Services tend to be member specific and often arranged through a plan of care. Atypical providers who render services for HCBS waivers may not have authorization, or may not adjudicate in the same manner as other health care providers. This business process begins with receipt of HCBS information from the ***Process Claim*** business process or capitation information from ***Process Encounter*** business process, performing required manipulation according to business rules, and formatting the results into the required information. The capitation payment activity includes a per-member-per-month payment for	This process addresses payments that are created without claims or reported outside the remittance process. Most HCBS payments are processed in VAMMIS through normal claims processing. (These payments are not addressed in this process.) However, PPL (attendant payroll for consumer directed waiver and MFP transition services) and visit and screening services for DD waiver are paid outside of VAMMIS. MCO/ Medicare-Medicaid Plan (MMP) (CCC) payments are reported via X12 820 transactions. DMAS does not have a PCCM program. The transportation vendor receives a payment based on a capitation rate. Payments are created for ASO vendors (e.g., dental, behavioral health) based on encounters.

OM Payment and Reporting		
Prepare Provider Payment		
Item	**Details**	**DMAS Differences/Comments**
	Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This business process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement (TPA) and includes retrieving enrollment and benefit transaction information from the Member data store, retrieving the rate information associated with the plan from the Provider or Contractor data store, and formatting the payment into the required information.	
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Alert from ***Process Claim*** business process to prepare HCBS payment. • Alert from ***Process Encounter*** business process to prepare capitation payment. Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., monthly) is due for capitation payment.	An invoice from PPL or DBHDS trigger HCBS payments Encounters for ASO services (dental, BHSA) trigger payments Monthly for MCOs, MMPs, and transportation vendor
Result	• Generated Provider's payment report. • Alert to send HCBS payment information to member. • Alert to send capitation payment information to member. • Tracking information as needed for measuring performance and business activity monitoring.	Alert sent to vendor, not member Alert sent to MCO, MMP, or vendor, not member
Business Process Steps	<u>HCBS Payment</u> 1. **START:** Receive alert from ***Process Claim*** business process.	Start is based on receipt of invoice

OM Payment and Reporting		
Prepare Provider Payment		
Item	**Details**	**DMAS Differences/Comments**
	2. Perform required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, such as bundling or unbundling of services.	
	3. Calculate payment amount.	Send alert to vendor, not member
	4. Generate payment report.	
	5. **END:** Send alert to submit HCBS payment information to member.	Performed monthly for MCOs, MMPs, transportation vendor
	Capitation Payment 1. **START:** Periodic timetable is due for capitation payment.	Capitation claims are system generated which results in minimal errors
	2. Perform required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, such as bundling or unbundling of services.	
	3. Calculate payment amount.	
	4. Generate payment report.	
	5. **END:** Send alert to submit capitation payment information to member.	Send alert to MCO/MMP, not member ASO Payment 1. **START:** Receive alert from ***Process Encounter*** business process. 2. Perform required information manipulation according to

OM Payment and Reporting		
Prepare Provider Payment		
Item	**Details**	**DMAS Differences/Comments**
		business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, such as bundling or unbundling of services. 3. Calculate payment amount. 4. Generate payment report. 5. **END:** Send alert to submit payment information to ASO
Shared Data	Claims data store including payment information Reference data store including code set, drug formulary, and service code formulary information Care management data store including prior authorization information Member data store including demographics and third-party insurance information Provider data store including provider network and contract information Contractor data store including provider network and contract information Financial data store including accounts payable information	
Predecessor	***Process Claim*** ***Process Encounter***	Also process invoice for HCBS payments
Successor	**Send Outbound Transaction** ***Manage Contractor Payment***	
Constraints	The ***Prepare Provider Payment*** business process will adhere to the federal and state	

OM Payment and Reporting		
Prepare Provider Payment		
Item	**Details**	**DMAS Differences/Comments**
	policies and business rules that may differ by state.	
Failures	• No alerts received from ***Process Claim*** or ***Process Encounter*** business processes.	
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within__hours • Accuracy with which rules are applied = % • Consistency with which rules are applied= ___% • Error rate = ____% or less	Capitation payments are made in the first payment cycle of the month Vendor invoices are paid within 7 days Provider clean claims are paid within 17 days of claims being presented to MMIS. Accuracy = 100% Consistency = 100% Error rate = 0%

3.7.1.3.2 As-Is Assessment

The overall rating for the Prepare Provider Payment business process is '2.' This process addresses payments that are created without claims or reported outside the remittance process with a focus on Home and Community Based Services (HCBS) payments. At DMAS, most HCBS payments are processed in the MMIS through the Claims Adjudication processes and are not addressed in the Prepare Provider Payment business process. However, attendant payroll for consumer directed waiver, MFP transition services, and visit and screening services for DD waiver are addressed by this business process.

Other items noted in the As-Is assessment were:

- MCO/ Medicare-Medicaid Plan (MMP) (CCC) payments are reported via X12 820 transactions.
- DMAS does not have a PCCM program.
- The transportation vendor receives a payment based on a capitation rate.
- Payments are created for ASO vendors (e.g., dental, behavioral health) based on encounters.

3.7.1.3.3 To-Be Assessment

DMAS intends to achieve an overall Level 3 for the Prepare Provider Payment business process.

Specific changes identified include:

- Identify opportunities to make this process more automated to improve timeliness and efficiency in a cost-effective manner, including information collection
- Pursue increased standardization and sharing of information that could improve accuracy and effectiveness
- Identify and capture performance measures and use them to identify additional improvements.

3.7.1.3.4 Scorecard

The following scorecard was compiled for the Prepare Provider Payment business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
Operations Management Prepare Provider Payment	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		

Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.7.1.4 Manage Data

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Data business process.

3.7.1.4.1 Business Process Model

The Manage Data business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

OM Payment and Reporting		
Manage Data		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Data*** business process is responsible for the preparation of the data sets and delivery to federal agencies (e.g., Centers for Medicare & Medicaid Services (CMS), Social Security Administration (SSA).) Information exchange may include extraction of Medicaid and CHIP Business Information and Solutions (MACBIS) information needs (i.e., fee-for-services, managed care, eligibility and provider information). The ***Manage Data*** business process includes activity to extract the information, transform to the required format, encrypt for security, and load the electronic file to the target destination. The uses for the information include: • Research and evaluation of health care activities. • Staff can forecast the utilization and expenditures for a program. • Staff can analyze policy alternatives. • State and federal agencies can respond	The scope of this process is defined to include: • T-MSIS • Quarterly DHHS OIG claims data extract • Quarterly MFP (may be retired based on T-MSIS) • PERM • CCC (Duals) • Ad hoc requests, e.g., from OIG

OM Payment and Reporting		
Manage Data		
Item	**Details**	**DMAS Differences/Comments**
	to congressional inquiries. • Matches to other health related databases.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic (e.g., quarterly) timetable for information is due. • Receive request for information.	
Result	• Information message sent to target destination. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive time event or request to initiate ***Manage Data*** business process. 2. Extract required information from source data stores. 3. Transform information to meet business and technical needs of target destination. 4. Apply necessary encryption algorithms for security. 5. **END:** Send message with information to the target destination.	
Shared Data	Claims data store including claims, encounters, adjudication, and historical information Care management data store including treatment plan, outcomes, and authorization information Plan data store including Medicaid State Plan, health plan, health benefits, reference, performance measures, and benchmarks information	Limited to authorization information Care Management and Compliance Incident data are not currently included but could be included in ad hoc requests

OM Payment and Reporting		
Manage Data		
Item	**Details**	**DMAS Differences/Comments**
	Compliance Incident data store including anomalies and adverse action information Member data store including demographics, eligibility determination, enrollment, grievance and appeals, communication, and outreach information Provider data store including provider network, eligibility determination, enrollment, grievance and appeals, communication, and outreach information Contractor data store including provider network, enrollment, grievance and appeals, communication, and outreach information Financial data store including accounts payable and accounts receivable information	
Predecessor	**NOTE:** Many MITA Framework business processes collect data for extraction of information and send to target destination. The following are the business processes that manage primary data stores. ***Manage Case Information*** ***Manage Contractor Information*** ***Manage Member Information*** ***Manage Provider Information*** ***Manage Budget Information*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Information*** ***Generate Financial Report*** ***Process Claim*** ***Process Encounter*** ***Generate Remittance Advice*** ***Manage Compliance Incident Information***	

OM Payment and Reporting		
Manage Data		
Item	**Details**	**DMAS Differences/Comments**
	Maintain State Plan ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures*** ***Manage Reference Information***	
Successor	**Send Outbound Transaction**	See note above for specific outbound transactions
Constraints	The ***Manage Data*** business process will adhere to the federal requirements for submission of information to federal agency.	
Failures	• Requested information is not available for extraction. • Transformation does not meet the federal requirements for submission. • Information message does not meet the target destination submission requirements.	
Performance Measures	• Time to complete the process: e.g., Real Time response = within ____seconds, Batch Response = within ___ hours • Accuracy with which the State Medicaid Agency (SMA) applies rules =____% • Consistency with which the SMA applies rules =___% • Error rate = ____% or less	All data transfers are delivered per requirements for each item Any errors are corrected as needed to gain 100% accuracy/approval 100% 0%

3.7.1.4.2 As-Is Assessment

The overall rating for the Manage Data business process is '2.' The DMAS Manage Data process supports several federally required extracts for example, T-MSIS, Quarterly DHHS OIG claims data extract, Quarterly Money Follows the Person (MFP), Payment Error Rate Measurement (PERM) Audits, Commonwealth Coordinated Care (Duals demonstration). Ad hoc requests for information such as those received from the Office of Inspector General (OIG) are also supported. While some of these data related processes are automated, some are manual.

Other items noted in the As-Is assessment were:

- The Business Capability Assessment for Accuracy was rated as Level 3
- MFP and PERM utilize some manual processes
- Recurring extracts for OIG and MSIS (T-MSIS) are automated
- State and/or industry standards are met for required contents and delivery schedules
- There is no collaboration with other agencies/entities

3.7.1.4.3 To-Be Assessment

DMAS intends to achieve an overall Level 3 for the Manage Data business process.

Specific changes identified include:

- Identify opportunities to make this process more automated to improve timeliness and efficiency in a cost-effective manner, including automation of the ETL process to the full extent possible
- Leveraging our data to more easily meet T-MSIS reporting, such as avoiding data crosswalks
- Work with external sources of information to use industry standards for information exchange
- Increase use of industry standards, and information exchange with intrastate agencies and entities, to improve accuracy and effectiveness
- Identify and capture performance measures and use them to identify additional improvements.

3.7.1.4.4 Scorecard

The following scorecard was compiled for the Manage Data business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
Operations Management Manage Data	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		

Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.7.2 Claims Adjudication

As shown in Figure 3.7-1, the Claims Adjudication business category is made up of five business processes:

- Process Claims
- Process Encounters
- Calculate Spend-Down Amount
- Submit Electronic Attachment
- Apply Mass Adjustment

Details regarding the assessment of each Claims Adjudication business process follow.

3.7.2.1 Process Claims

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Process Claims business process.

3.7.2.1.1 Business Process Model

The Process Claims business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

OM Claims Adjudication		
Process Claim		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Process Claim*** business process receives original or adjusted claim (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction, assigns an internal control number, and • Determines its submission status, and based on that: o Performs Claims Edits: ✓ Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction. ✓ Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding. o Performs Claims Audits: ✓ Verify against historical information. ✓ Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity. o Suspends claim that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules. o Applies National Correct Coding Initiative (NCCI) Edits. o Applies Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate. o Prices Claims: ✓ Calculate state allowed amount. ✓ Calculate paid amount.	Pharmacy is submitted POS. DMAS accepts paper, although it is discouraged.

OM Claims Adjudication		
	Process Claim	
Item	**Details**	**DMAS Differences/Comments**
	NOTE: All fee-for-services claim types will go through most of the business process steps but with different business rules associated with the different claim types. Both Centers for Medicaid & Medicaid Services (CMS) and state policy determine business rules for claims edits, audits, and pricing methodologies. State business rules define whether the State Medicaid Agency (SMA) pays, suspends, flags for information, or denies a claim. State business rules define whether an edit is fatal or non-fatal as well. *See Constraints*. **NOTE:** An adjustment to a claim is on an exception use case to this business process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the payment information. **NOTE:** This business process is part of a suite including ***Calculate Spend-down Amount, Submit Electronic Attachment***, and ***Generate Remittance Advice*** business processes.	DMAS uses 3M APR/DRG for inpatient and EAPG for outpatient/ambulatory.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive claim via Accredited Standards Committee (ASC) X12 837 Health Care Claim fee-for-services claims transactions. • Receive Retail Pharmacy Claim Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). Environment-based Trigger Events to include but not limited to: • Receive a scanned or direct-data-entered paper claim. • Periodic (e.g., daily, weekly) adjudication/payment cycles is due.	System generates claims, e.g., for capitation, ClaimCheck editing, Assessment, and case building.
Result	• The SMA adjudicates a claim. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to send to submitter via ASC X12 277 Health Care Information Status Notification for requesting additional	DMAS sends a 997 and 999. A 277U is sent for pended claims.

OM Claims Adjudication		
	Process Claim	
Item	**Details**	**DMAS Differences/Comments**
	information. • If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to ***Generate Remittance Advice*** business process with payment and/or error report information. • Alert sent to ***Prepare Provider Payment*** business process for payment. • If applicable, alert sent to send to ***Manage TPL Recovery*** business process for third-party insurance. • Alert sent to ***Manage Accounts Receivable Information*** business process with payment information. • Alert sent to ***Manage Accounts Payable Information*** business process with HCBS payment information. • Tracking information as needed for measuring performance and business activity monitoring.	ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) are not received (or processed).
Business Process Steps	1. **START:** Receive claim submission or claim adjustment information. 2. Perform Fatal Edits: a. If electronic claim submission, perform ASC X12N edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon Levels 1-7 stated in the Trading Partner Agreement. i. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. b. Validate that claim submission meets filing deadlines based on service dates. c. If applicable, reject claim for electronic or paper claim fatal validation errors and	2: An entire group of claims (ST-SE) is rejected if a fatal error is found. 2.i: A 997 or 999 is sent. 2b: Timely filing is not a fatal edit; it is an adjudication denial

OM Claims Adjudication		
	Process Claim	
Item	**Details**	**DMAS Differences/Comments**
	send alert to ***Generate Remittance Advice*** business process with error report information. **END:** Business process stops. 3. Perform Non-Fatal Edits: a. Determine claim status as initial, adjustment to a processed claim, or a duplicate submission that is already in the adjudication process, but not yet completed and loaded into payment history (using a unique Patient Account Number). i. If applicable, associate the claim adjustment to the original claim submission. b. Validate provider information (e.g., provider taxonomy, National Provider Identification (NPI), enrollment status, approved to bill for this service). c. Validate member information (e.g., Member's eligibility status on the date of service, apply third-party resources to the claim). i. If applicable, alert sent to ***Manage TPL Recovery*** business process for third-party insurance. d. Validate member's health benefit covers the service and apply appropriate rules. For example: i. Because adult member benefit package does not cover dental services, deny the claim. ii. Member is in another health plan that is their primary insurance, and the Medicaid covers the same service. Designate the claim for the Coordination of Benefits (COB) and deny the claim. Under a payer-to- payer business model, the primary payer receives the COB claim. e. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status.	2c: Rejected claims do not appear on a remittance advice but adjudication denials do appear on a remittance advice. 3.i: DMAS uses a TPL vendor for TPL Recovery. This process does not generate a COB claim, but payer-to-payer claims are submitted by HMS as part of the ***Manage TPL Recovery*** process.

OM Claims Adjudication		
	Process Claim	
Item	**Details**	**DMAS Differences/Comments**
	f. If provider submits service authorization, referral or treatment plan number, verify the number, member, provider, service, and date(s) of service. If state-defined business rules identify certain edits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate Path: Suspended Claim below.	
	4. Perform Audits:	
	a. Check payment history for duplicate processed claim using search key information such as in-house claim number, date of service, provider and member demographics, service, and diagnosis codes.	
	b. If provider did not submit service authorization, referral or treatment plan, and one exists on file, validate number, member, provider, service, and date(s) of service against claims history.	b: This is only performed for outpatient scans.
	c. Check Clinical Appropriateness of the services provided based on clinical, case, and disease management protocols.	c: This is addressed through service authorization requirements.
	d. Perform Prospective Payment Integrity Check.	
	e. If state-defined business rules identify certain audits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate Path: Suspended Claim below.	
	5. Validate National Correct Coding Initiative (NCCI) (bundle/unbundle codes).	5: McKesson ClaimCheck and 3M EAPG COTS software are used for NCCI editing.
	6. If applicable, apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules, as appropriate.	
	7. Perform Pricing:	6: 3M EAPG COTS software is used for Outpatient and Ambulatory Surgery claims
	a. Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC).	
	8. Check for presence of Coordination of Benefits (COB) claim information.	8: Claim is denied if other

OM Claims Adjudication		
	Process Claim	
Item	**Details**	**DMAS Differences/Comments**
	a. If COB is present: i. Set status to Deny claim. iii. Flag and move claim to COB file. iv. Send alert to ***Send Outbound Process*** with claim adjudication information and claim.	payer indicated is not billed first 8.a.iii: No separate COB file. Claims are sent to COB vendor for ***Manage TPL Recovery*** process.
	9. Send alert to ***Generate Remittance Advice*** business process with payment information.	
	10. Send alert to ***Manage Accounts Receivable Information*** business process with payment information.	Adjudicated claims files are sent to a variety of business partners.
	11. Send alert to ***Manage Accounts Payable Information*** business process with payment information.	
	12. **END:** Send alert to ***Prepare Provider Payment*** business process for payment.	
	Alternate Path: Suspended Claim	
	1. **START:** Claim has an assigned suspended status.	
	2. Conduct Internal review	
	If applicable, reviewer requests further information as an alert sent to requestor via ASC X12 277 Health Care Information Status Notification.	277U for pended claims
	i. If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). ii. Internal review makes a determination to resolve the edit or audit in question. iii. **END:** Business process stops.	2.i: These transactions are not received
	3. Provider submits corrected information in response to an error notification.	
	a. The claim passes the edit or audit based on additional information submitted in response to a request, such as the ASC X12 277 Health Care Information Status Notification.	3.a: Providers can also be notified about pended claims via the portal and AVRS.

OM Claims Adjudication		
	Process Claim	
Item	**Details**	**DMAS Differences/Comments**
	NOTE: The ***Submit Electronic Attachment*** business process generates this request and reviews the response to validate that the additional information submitted is sufficient to pass the edit or audit. 4. If there is a favorably resolved suspended claim: a. Send alert to ***Generate Remittance Advice*** business process with adjudicated claim information. b. Go to step 7 of the ***Process Claim*** business process. c. **END:** Business process stops. 5. If provider submits a corrected claim, process it as if it is an original claim. a. Go to step 2 of the ***Process Claim*** business process. b. **END:** Business process stops. 6. If there is an unfavorably resolved suspended claim, send alert to ***Generate Remittance Advice*** business process with error report information. These include failures because the additional information requested for a suspended claim is not present, is inadequate or fails to satisfy the edit or audit. 7. **END:** The SMA resolves the suspended claim. <u>Alternate Path: Third Party Liability Failures</u> 1. **START:** The SMA identifies a third-party resource. 2. If a Cost Avoidance for third-party liability exists, reject claim for edit errors. 3. Send alert to ***Manage TPL Recovery*** business process for third-party insurance recovery. 4) **END:** Send alert to ***Generate Remittance Advice*** business process with Edit Error Report information.	Providers cannot submit claim corrections. Providers submit new (corrected) claims in response to denials. 6: Pended claims are resolved either through automatic recycling or on-line action by DMAS or fiscal agent. 3: Some COB claims are processed as 'pay and chase.'
Shared Data	EDI Translator data store including ASC X12 Implementation Guide Validation Edits for Levels 1 through	

OM Claims Adjudication		
	Process Claim	
Item	**Details**	**DMAS Differences/Comments**
	7 Claim data store including payment, in-house claim number, and Patient Account Number information Provider data store including performing prospective program integrity (e.g., Healthcare Integrity and Protection Data Bank (HIPDB)) and Medicare/Medicaid sanctions information, provider network, and contract information Member data store including demographics, third-party insurance information, and member-specific pricing Plan data store including health benefit information (e.g., covered services, units, life-time limits, units and funding limits for authorized services, and benefit package-specific rates) Reference data store including filing deadlines, code set, drug formulary, and service code formulary. Additional information includes Diagnosis Related Group (DRG), Ambulatory Payment Classification (APC), and National Correct Coding Initiative (NCCI) information Authorization data store including authorization and treatment plan information Rate setting data store including applicable rates Claims data store including adjudication and payment history information Financial data store including accounts receivable and accounts payable information	DMAS does not share with HIPDB but we do use LEIE and MCSIS Budget information is also checked and claims can be pended if budget is exceeded
Predecessor	***Receive Inbound Transaction*** ***Submit Electronic Attachment***	DMAS does not process electronic attachments; attachments (paper, physical) are sent separately from the claim
Successor	***Send Outbound Transaction*** ***Calculate Spend-down Amount*** ***Generate Remittance Advice*** ***Prepare Provider Payment*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Disbursement*** ***Manage TPL Recovery***	This business process does not include "calculate spend-down amount" as a successor. Spend-down is calculated by DSS as a pre-requisite to Medicaid enrollment.

OM Claims Adjudication		
	Process Claim	
Item	**Details**	**DMAS Differences/Comments**
	Submit Electronic Attachment Manage ***DataManage Performance Measures***	DMAS does not send electronic attachments.
Constraints	All claim types will go through most of the steps within the Process Claim business process main flow with some variance of business rules and information. Types of claim variances include: Institutional, Professional, Dental, Pharmacy, and Waiver claims, Medicare Crossover and Medicare Part D pharmacy claims, coordination of benefits claims received from payers secondary to Medicaid (e.g., for IHS eligibles), and TPL cost-avoided claims. The business rules will conform to federal and state-specific rules and pricing algorithms. Editing, auditing, and pricing variances could exist on services billed by claim type, provider taxonomy code, service line codes, and the process may require additional information. An adjustment to a claim follows the same business process path except that it requires a link to the previously submitted and processed claim in order to reverse the original claim payment, and associate the original to the adjustment.	Dental services are all submitted as encounters Medicare Part D claims are not received Claims are not received from other payers.
Failures	The **Process Claim** business process contains a series of potential points of failure. The claim could fail any edit or audit. Business rules define whether one or more edit or audit failures will result in suspending or denying the claim. Fatal Edit Failures: Claim information has fatal edit error. For example: • Claim submitted without all the required information. • Provider files claim after claim filing deadline. Other Edit Failures: Claim information has other errors. For example:	Compliance checking is Level 1-4 in the HIPAA 5010 compliance checker, Xerox currently uses SYBASE. Timely filing is not a fatal edit; it is an adjudication denial.

OM Claims Adjudication		
Process Claim		
Item	**Details**	**DMAS Differences/Comments**
	• The SMA does not cover the service because not in health benefit, not provided in an approved facility or by an approved provider type. • Service is not appropriate based on member demographics. • Member has TPL coverage.	
Performance Measures	• Time to complete the process: e.g., Real Time response = within seconds, Batch Response = within hour • Accuracy with which edits, audits and pricing algorithms are applied and paid amount is calculated =_____% • Consistency of decisions on suspended claims = ___% • Error rate = % or less	**Time to Complete:** Electronic Claims ≤ 24 hours Paper Claims within ≤ 72 hours POS payment requests an average response aggregate ≤ 3 seconds For online process, re-adjudicate payment requests ≤30 seconds For batch process, re-adjudicate payment requests ≤ one business day unless defined by a specific edit. **Accuracy:** 100% (certified through manual QA) **Consistency:** 100% (results are spot checked) **Error Rate:** 0% See excerpts from the Xerox MMIS service level agreements below.

Fiscal Agent Service Level Agreements (SLAs):

DEFINITION	MMIS Batch Processing for MMIS is defined as the ability of the technical infrastructure to complete enterprise-wide mission critical batch business processing.

MMIS Batch Processing Service Level Service Level Requirements				
ID	**Batch Processing Type**	**Service Measure**	**Performance Target**	**Minimum Performance %**
1	Receive, control, assign a unique ICN, image, transfer to MMIS and adjudicate all paper payment requests and their attachments or any other associated claims documents.	Timeliness	Process paper payment requests from receipt through adjudication ≤ 72 hours.	99.5%
2	Receive, assign a unique ICN, establish proof report and adjudicate all to EDI and DDE payment requests (Claims and Encounters).	Timeliness	Process Fee-for-Service EDI and DDE payment request from receipt through adjudication ≤ 24 hours. Process encounter EDI payment requests from receipt through adjudication ≤ 48 hours. Benchmark time for measurement purposes are weekdays at 5PM	99.5%
3	Receive, assign a unique ICN, adjudicate and return an average response for all POS payment requests.	Timeliness	Process POS payment requests from receipt through an average response aggregate ≤ 3 seconds (enterprise response).	99.5%
4	Process all EDI and DDE transmissions in MMIS, excluding encounters.	Timeliness	100% return a 997 transaction for claims transmissions ≤ 1 hour of receipt. 100% return a 997 transaction for all other inputs ≤ 4 hours of receipt.	95%
5	For batch process, re-adjudicate payment requests by performing all edits, audits, and pricing after release from pend resolution.	Response	≤ one business day unless defined by a specific edit.	99.5%

DEFINITION	Online Response Time for MMIS online applications is defined as the ability of the applications to respond to online enterprise-wide mission critical business processing and functions.

MMIS Application Response Time Service Level				
ID	**Application**	**Service Measure**	**Performance Target**	**Minimum Performance %**

MMIS Batch Processing Service Level Service Level Requirements				
ID	Batch Processing Type	Service Measure	Performance Target	Minimum Performance %
1	For online process, re-adjudicate payment requests by performing all edits, audits, and pricing after release from pend resolution.	Response	≤30 seconds	99%

3.7.2.1.2 As-Is Assessment

The capability level for the Process Claims business process is '2.' In many instances the business process was consistent with the MITA 3.0 framework. For example, DMAS is HIPAA 5010 and CORE compliant. Most providers submit claims using the HIPAA 5010 standards or enter claims using the Claims Direct Data Entry. The MMIS business rules and reference tables can be updated online by business users in some cases. The process was rated as very accurate due to use of HIPAA transactions and industry standard business rules and edits.

Other items noted in the As-Is assessment were:

- DMAS still accepts and processes a small number paper claims.
- Pended Claims require manual review in some cases and are not processed within 24 hours.
- The MMIS does not support electronic attachments, but some edit rules do use the existence of an attachment.
- Some edits/audits and other business rules are not table driven and must be updated by a programmer.
- Use of manual review and decision processes relative to pend resolution.
- DMAS does not utilize business rules engines used by other intrastate agencies and entities.

3.7.2.1.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Process Claims business process:

- Reduce manual interventions by decreasing/eliminating the submission of paper claims.
- Improve the timeliness of the resolution of pended claims to less than 24 hours by better collaboration across programs.
- Edits/audit and business rules should be a one stop shop and minimal to no manual intervention.
- Collaboration with other intrastate agencies to adopt national standards and to develop and share reusable business services for claims processing.

3.7.2.1.4 Scorecard

The following scorecard was compiled for the Process Claims business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
Claims Adjudication Process Claim	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.7.2.2 Process Encounters

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Process Encounters business process.

3.7.2.2.1 Business Process Model

The Process Encounters business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

OM Claims Adjudication		
Process Encounter		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Process Encounter*** business process receives original or adjusted encounter (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction and determines its submission status, and based on that: • Performs Encounter Edits: o Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction. o Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding. • Performs Encounter Audits: o Verify against historical information. o Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity. • Suspends encounter that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules. o Apply National Correct Coding Initiative (NCCI) Edits. o Apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate.	All EDI – 837 & NCPDP Encounters do not apply service authorizations, clinical appropriateness, and payment integrity edits.

OM Claims Adjudication		
	Process Encounter	
Item	**Details**	**DMAS Differences/Comments**
	○ Prices Encounters: ✓ Calculate state allowed amount. ✓ Calculate paid amount. ✓ Set paid amount to zero dollars. **NOTE:** All encounters will go through most of the business process steps but with different business rules associated with the different encounter claim types. Both Centers for Medicare & Medicaid Services (CMS) and state policy determine business rules for encounter edits, audits, and pricing methodologies. State business rules define whether an encounter goes to a To-Be-paid status, suspends, flags for information, or denies. State business rules define whether an edit is fatal or non- fatal as well. *See Constraints*. **NOTE:** An adjustment to an encounter is on an exception use case to this business process that follows the same process path except it requires a link to the previously submitted processed encounter in order to reverse the original encounter and associate the original and replacement encounter in the calculation information. **NOTE:** This business process is part of a suite including ***Calculate Spend-down Amount, Submit Electronic Attachment***, and ***Generate Financial Report*** business processes.	Encounters do not suspend NCCI edits are not performed by the MCO plans for Managed Care Encounters. NCCI edits are performed by Magellan for the behavioral health encounters. DMAS collects the MCO paid amount MCOs submit paid and denied claims. The encounter process results in possible edits that indicate a error severity level. Status 9 represents an MCO denial.

OM Claims Adjudication		
Process Encounter		
Item	**Details**	**DMAS Differences/Comments**
		These processes do not apply.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive encounter via Accredited Standards Committee (ASC) X12 837 Health Care Claim encounter transactions. • Receive Retail Pharmacy Encounter Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., daily, weekly) is due for adjudication and payment cycles.	Encounters are adjudicated only, not paid
Result	• The State Medicaid Agency (SMA) adjudicates an encounter. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to send to submitter via ASC X12 277 Health Care Information Status Notification for requesting additional information. • If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to Prepare Provider Payment business process for capitation payment. • If applicable, alert sent to Generate	Only a 999 is sent; NCPDP gets RSP TA1 transaction not used This is not applicable This is not applicable

OM Claims Adjudication		
	Process Encounter	
Item	**Details**	**DMAS Differences/Comments**
	Financial Report business process with payment and/or error report information. • If applicable, alert sent to send to Manage TPL Recovery business process for third-party insurance. • Tracking information as needed for measuring performance and business activity monitoring.	This is not applicable Proprietary reports and error files are sent to provide information on results TPL is not applicable, but is performed by MCOs Dental, Transportation and Magellan will all coordinate/apply TPL on a 'normal' basis. For MCOs, once TPL is confirmed, member is then carved-out of Managed Care and returned to FFS.
Business Process Steps	1. **START:** Receive encounter submission or encounter adjustment information. 2. Perform Fatal Edits: a. If electronic encounter submission, perform ASC X12N edits for valid syntax and format, identifiers and	Compliance checking is

OM Claims Adjudication		
	Process Encounter	
Item	Details	DMAS Differences/Comments
	codes, dates, and other information required for the transaction according to the agreed-upon Levels 1-7 stated in the Trading Partner Agreement.	Level 1-4 only
	i. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops.	A 999 is sent; NCPDP gets RSP.
	b. Validate that encounter submission meets filing deadlines based on service dates.	Timely delivery of the files is based on contractual requirements and is a manual process, rather than service dates.
	c. If applicable, reject encounter for electronic fatal validation errors and send alert to ***Generate Financial Report*** business process with error report information. **END:** Business process stops.	Timely filing (as it relates to the claim) is applied by the Contractors/Vendors.
	3. Perform Non-Fatal Edits:	Rejects are at ST-SE level; reported on 999 (X12) or RSP (NCPDP). Error details are reported on a proprietary file (EFL).
	a. Determine encounter status as initial, adjustment to a processed encounter, or a duplicate submission that is already in the adjudication process but not yet completed and loaded into encounter payment history (using a unique Patient Account Number).	
	i. If applicable, associate	

OM Claims Adjudication		
	Process Encounter	
Item	Details	DMAS Differences/Comments
	encounter adjustment to original encounter submission. b. Validate provider information (e.g., provider taxonomy, NPI, enrollment status, approved to bill for this service). c. Validate member information (e.g., demographics, eligibility status on the date of service). d. Validate the SMA covers service in member's health benefit and apply appropriate rules. For example: i. Adult member benefit package does not cover dental services so deny the encounter. e. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status. f. If provider submits service authorization, referral or treatment plan number, verify the number, member, provider, service, and date(s) of service. g. If state defined business rules identify certain edits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to ***Generate Financial Report*** business process with error report information. **END:** Business process stops. 4. Perform Audits: a. Check encounter history for duplicate processed	Provider taxonomy is not validated, but it is used if provided and needed. Service authorization, referral and treatment plan number are not validated.

OM Claims Adjudication		
	Process Encounter	
Item	Details	DMAS Differences/Comments
	encounter using search key information such as in-house encounter number, date of service, provider and member demographics, service, and diagnosis codes.	Encounters are not suspended. Errors are sent on a proprietary report.
	b. If provider did not submit service authorization, referral or treatment plan, and one exists on file, validate number, member, provider, service, and date(s) of service against claims history.	
	c. Check Clinical Appropriateness of the services provided based on clinical, case, and disease management protocols.	Duplicate batches, when identified, are not processed
	d. Perform Prospective Payment Integrity Check.	
	e. If state defined business rules identify certain audits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to Generate Financial Report business process with error report information. END: Business process stops.	Service authorization, referral and treatment plan number are not validated.
	5. Validate National Correct Coding Initiative (NCCI) (bundle/unbundle codes).	Clinical appropriateness is checked in the Contractor/Vendor system and not rechecked when the encounter is submitted to VAMMIS.
	6. If applicable, apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules.	
	7. Perform Pricing (Shadow-Pricing):	
	a. Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC).	Encounters derive a payment amount per FFS payment rules

OM Claims Adjudication		
	Process Encounter	
Item	**Details**	**DMAS Differences/Comments**
	b. Calculates To-Be-paid amount by deducting: i. Contributions provided by Member. ii. Provider advances, liens, and recoupments. 8. Send alert to ***Prepare Provider Payment*** business process for payment. 9. **END:** Send alert to ***Generate Financial Report*** business process with payment information. <u>Alternate Path: Suspended Encounter</u> 1. **START:** Provider submits corrected information in response to an error notification. 2. Process it as if it is an original encounter. a. Go to step 2 of the ***Process Encounter*** business process. **END:** Business process stops.	when sufficient data is available. Encounters are not suspended. Errors are sent on a proprietary report. NCCI edits not performed by the MCO plans for Managed Care Encounters. NCCI edits are performed by Magellan for the behavioral health encounters. Provider advances, liens, and recoupments are not applicable MCO Payments are not made based on encounter processing, with the exception of Magellan.

OM Claims Adjudication		
Process Encounter		
Item	**Details**	**DMAS Differences/Comments**
		Once R67 is implemented, Magellan's weekly add-pays will be paid directly from the encounter files. A financial report is not generated, but errors are reported. Encounters are not suspended; this path is not applicable.
Shared Data	• EDI Translator data store including ASC X12 Implementation Guide Validation Edits for Levels 1 through 7 encounter data store including payment, in-house encounter number, and Patient Account Number information • Provider data store including performing prospective program Integrity (e.g., HIPDB) and Medicare/Medicaid sanctions information, provider network, and contract information • Member data store including demographics, eligibility, enrollment, and member- specific pricing • Plan data store including health benefit information (e.g., covered services, units, life-time limits, units and funding limits for authorized services, and benefit package-specific rates) • Reference data store including filing deadlines, code set, drug formulary, and service code formulary. Additional information includes Diagnosis Related	Compliance edits are limited to Levels 1-4. This is not applicable.

OM Claims Adjudication		
	Process Encounter	
Item	**Details**	**DMAS Differences/Comments**
	Group (DRG), Ambulatory Payment Classification (APC), and National Correct Coding Initiative (NCCI) information • Authorization data store including authorization and treatment plan information Rate setting data store including applicable rates • Encounter data store including adjudication and encounter payment history information • Financial data store including accounts receivable and accounts payable information	This is not applicable. This is not applicable. Add Transportation Files to shared data
Predecessor	**Receive Inbound Transaction** **Submit Electronic Attachment**	DMAS does not receive electronic attachments.
Successor	**Send Outbound Transaction** **Calculate Spend-down Amount** **Generate Financial Report** **Submit Electronic Attachment** **Manage Data**	**Not applicable for DMAS:** **Calculate Spend-down Amount** **Generate Financial Report** **Submit Electronic Attachment**

OM Claims Adjudication		
Process Encounter		
Item	**Details**	**DMAS Differences/Comments**
Constraints	All encounter claim types will go through most of the steps within the Process Encounter business process main flow with some variance of business rules and information. Types of encounter variances include: Institutional, Professional, Dental, Pharmacy, and Waiver encounters; Medicare Crossover and Medicare Part D pharmacy encounters; and Coordination of Benefits (COB) encounters received from payers secondary to Medicaid (e.g., for IHS eligibles). The business rules will conform to federal and state-specific rules and pricing algorithms. Editing, auditing, and pricing variances could exist on services billed by encounter claim type, provider taxonomy code, service line codes, and the process may require additional information. An adjustment to an encounter follows the same business process path except that it requires a link to the previously submitted and processed encounter in order to reverse the original encounter and associate the original to the adjustment.	Medicare Crossovers, Part D, Waivers are not applicable. DMAS does receive transportation and behavioral health encounters. Add CCC to the list of incoming encounters
Failures	The ***Process Encounter*** business process contains a series of potential points of failure. The encounter could fail any edit or audit. Business rules define whether one or more edit or audit failures will result in suspending or denying the encounter. Fatal Edit Failures: Encounter information has fatal edit error. For example: • Encounter submitted without all the	Encounters are not denied. An error severity level is assigned.

OM Claims Adjudication		
Process Encounter		
Item	**Details**	**DMAS Differences/Comments**
	required information. • Encounter submitted after encounter filing deadline. Other Edit Failures: Encounter information has other errors. For example: • The SMA does not cover the service because it is not in the health benefit, or is not in an approved facility or performed by an approved provider type. • Service is not appropriate based on member demographics.	Filing deadline is not a fatal error.
Performance Measures	• Time to complete Process Encounter business process: e.g., Real Time response = within seconds, Batch Response = within hour • Accuracy with which edits, audits, and pricing algorithms are applied and To-Be- paid and paid amount is calculated = _% • Consistency of decisions on suspended encounters = • Error rate = % or less	X12 encounters are held and processed on the weekend. NCPDP encounters are processed within 48 hours. 100% N/A 0%

3.7.2.2.2 As-Is Assessment

The capability level for the Process Encounter business process is '2.' In many instances the business process was consistent with the MITA 3.0 framework. For example, DMAS is HIPAA 5010 and CORE compliant. Managed Care Organizations (MCO) and other vendors that DMAS contracts with are required to submit encounters to DMAS using the HIPAA 5010 standard transactions. DMAS processes encounters through many of the same edits used for Fee for Service claims, to ensure that the quality of the encounter data is consistent and complete.

Other items noted in the As-Is assessment were:

- Service authorization, clinical appropriateness, and payment integrity edits are not applied to encounters in the MMIS.
- DMAS does not apply the NCCI edits to MCO encounters.
- The MCO plans are not contractually required by DMAS to perform NCCI edits on the claims that they process.
- Magellan is contractually required by DMAS to perform the NCCI edits on the behavioral health claims that they process.
- TPL is not applicable, but is performed by MCO plans.
- Dental, Transportation and Behavioral Health contractors will all coordinate/apply TPL on a 'normal' basis.
- For MCOs, once TPL is confirmed, member is then carved-out of Managed Care and returned to FFS.
- HIPAA 5010 compliance checking is Level 1-4 only.
- Proprietary reports and error files are sent to provide information on MMIS processing results.
- Encounters are not suspended.
- Duplicate batches, when identified, are not processed.

3.7.2.2.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Process Encounters business process:

- Require the MCO plans to implement NCCI editing rules for all applicable claim types
- Collaborate with other intrastate agencies and entities to adopt national standards, and to develop and share reusable business services.
- Improve overall quality of encounter data by implementing EDI translator validation edits beyond the current Levels of 1 through 4.
- In order to greatly improve data quality, DMAS needs the ability to accept and identify uniquely separate provider files from each MCO and Contractor vendor, separate and apart from the fee-for-service provider file.

3.7.2.2.4 Scorecard

The following scorecard was compiled for the Process Encounters business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
Claims Adjudication Process Encounter	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3

Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

***Fiscal Agent Service Level Agreements (SLAs)*:**

DEFINITION	MMIS Batch Processing for MMIS is defined as the ability of the technical infrastructure to complete enterprise-wide mission critical batch business processing.

MMIS Batch Processing Service Level Service Level Requirements				
ID	**Batch Processing Type**	**Service Measure**	**Performance Target**	**Minimum Performance %**

MMIS Batch Processing Service Level Service Level Requirements				
ID	Batch Processing Type	Service Measure	Performance Target	Minimum Performance %
2	Receive, assign a unique ICN, establish proof report and adjudicate all to EDI and DDE payment requests **(Claims and Encounters).**	Timeliness	Process Fee-for-Service EDI and DDE payment request from receipt through adjudication ≤ 24 hours. Process encounter EDI payment requests from receipt through adjudication ≤ 48 hours. Benchmark time for measurement purposes are weekdays at 5PM	99.5%

3.7.2.3 Calculate Spend-Down Amount

The Spend-Down Amount process is handled by Department of Social Services and it occurs before the applicant is allowed to enroll in the Virginia Medicaid program. There is no Spend-Down Amount business process at Virginia Medicaid.

3.7.2.4 Submit Electronic Attachment

Electronic Attachments have not been implemented for Virginia Medicaid. Paper attachments are manually submitted by providers, sent to Virginia Medicaid via U.S. mail and associated with the appropriate claim using an attachment control number. Attachments can be matched to the related pended claims.

DMAS does plan to evaluate the use of electronic attachments in the future to determine if they will provide an effective method to reduce pended claims and to collect clinical data.

3.7.2.5 Apply Mass Adjustment

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Apply Mass Adjustment business process.

3.7.2.5.1 Business Process Model

The Apply Mass Adjustment business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

OM Claims Adjudication		
Apply Mass Adjustment		
Item	**Details**	**DMAS Differences/Comments**
	The ***Apply Mass Adjustment*** business process begins with the receipt or notification of retroactive modifications. These changes may consist of modified rates associated with	The mass adjustment

OM Claims Adjudication		
Apply Mass Adjustment		
Item	**Details**	**DMAS Differences/Comments**
Description	Healthcare Common Procedure Coding System (HCPCS), Claim Payment/Advice Transaction (CPT), Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the payment transactions such as claims or capitation payment by identifiers (e.g., claim/bill type, HCPCS, CPT, Revenue Code(s), or member identification) that the State Medicaid Agency (SMA) paid incorrectly during a specified date range. The business process applies a predetermined set or sets of parameters that may reverse or amend the paid or denied transactions and repay correctly. **NOTE:** Do not confuse this process with the claim adjustment within the adjudication process. A mass adjustment may involve many previous payments based on a specific date or date range affecting single or multiple providers, members, or other payees. Likewise, mass adjustments historically refer to large- scale modifications in payments as opposed to disenrollment of a group of members from a Managed Care Organization (MCO)..	process can be used to void (reverse) claims. Denied claims are not adjusted, but they can be reprocessed through a similar selection process.
Trigger Event	Environment-based Trigger Event: • Receive a mass adjustment notification of retroactive rate or program modifications. • Correction of system errors resulting in incorrect payment amounts. • Identification of incorrectly denied claims	The need for a mass adjustment can be identified through an ISR (system change request). See note above; denied claims are not adjusted
Result	• Validated mass adjustment information applied to previous payment records. • If applicable, alert sent to notify member via ***Manage Applicant and Member Communication*** business process of relevant modifications. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of relevant modifications.	Members are not notified

OM Claims Adjudication		
	Apply Mass Adjustment	
Item	**Details**	**DMAS Differences/Comments**
	• If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of relevant modifications. • If applicable, alert sent to send to provider Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice transactions. • If applicable, alert sent to ***Manage Accounts Receivable Information*** business process of relevant modifications. • If applicable, alert sent to ***Manage Accounts Payable Information*** business process of relevant modifications. Tracking information as needed for measuring performance and business activity monitoring.	This would only be applicable for capitation claims and contacting MCOs.
Business Process Steps	1. **START:** Receipt or notification of incorrect payments or denials, based on retroactive rate modifications, program modifications, retroactive modifications in member eligibility, or system errors. 2. Identify the parameters necessary to locate claim records. 3. Enter parameters (i.e., corrected information). 4. Apply the predetermined set of parameters that reverse the incorrect payments or denials. 5. If applicable, produce mass adjustment request report. 6. Review the mass adjustment report for validity and accuracy. 7. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process of relevant modifications to their cost share. 8. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process of relevant modifications. 9. If applicable, send alert to send to provider ASC X12 835	Denied claims are not adjusted, however denied claims can be reprocessed through a similar selection process. Members are not notified

OM Claims Adjudication		
	Apply Mass Adjustment	
Item	**Details**	**DMAS Differences/Comments**
	Health Care Claim Payment/Advice transactions. 10. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of relevant modifications. 11. If applicable, send alert to ***Manage Accounts Receivable Information*** business process of relevant modifications. 12. If applicable, send alert to ***Manage Accounts Payable Information*** business process of relevant modifications. 13. **END:** Apply mass adjustment to previous payments.	This would only be applicable for capitation claims and contacting MCOs.
Shared Data	Claims data store with transaction information Provider data store with provider network and contract information Contractor data store with provider network and contract information Member data store with demographic information Plan data store including policy information Health Benefit data store including benefit program and benefit information Financial data store including accounts receivable and accounts payable information	This is applicable for MCOs
Predecessor	***Manage Provider Recoupment*** *Manage Cost Settlement*	Updating rates can be a predecessor
Successor	***Manage Provider Communication*** *Manage Contractor Communication*	

OM Claims Adjudication		
	Apply Mass Adjustment	
Item	**Details**	**DMAS Differences/Comments**
	Manage Applicant and Member Communication ***Process Claim*** ***Process Encounter*** ***Generate Remittance Advice*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Information***	Not applicable Encounters are not mass adjusted
Constraints	The mass adjustment will correctly identify payments for adjustments. Processes may vary by state.	
Failures	• Cannot locate all claims, capitation payments, or denials specified for adjustment.	
Performance Measures	• Time to complete the process: e.g., Real Time response = within ____ seconds, Batch Response = within ____hours • Accuracy with which edits, audits and pricing rules are applied = ___% • Error rate = ____% or less	The end-to-end process takes 4 business days 100% 0%

3.7.2.5.2 As-Is Assessment

The capability level for the Apply Mass Adjustment business process is '2.' In many instances the business process was consistent with the MITA 3.0 framework. For example, many aspects of the mass adjustment process are automated and large volumes of claims can be adjusted using precise selection criteria entered online by the business users.

Other items noted in the As-Is assessment were:

- DMAS does not contact members to notify them of a mass adjustment.
- The mass adjustment process can be used to void (reverse) claims.
- Denied claim are not adjusted, but they can be reprocessed through a similar selection process.
- Updates to rates are often a predecessor to Apply Mass Adjustments
- The end-to-end process takes 4 business days.
- A manual review and release of the claims to be adjusted is part of the process.
- Accuracy with which edits, audits and pricing rules are applied is 100%
- Some efficiency due to ability to set criteria but manual review steps and multiple days make it less efficient than fully automated.
- Larger mass adjustment requests can be sent to fiscal agent for processing.
- Encounters are not mass adjusted

3.7.2.5.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model will allow DMAS to reach a Level 3 rating for the Apply Mass Adjustment business process:

- Exceed state and federal requirements for fully automated and timely processing of mass adjustments with a "one stop" collaboration within the MMIS.
- Reduce the manual reviews and interventions and fully automate this process. This will lead to a decrease in the number of end- to-end process days.
- Automatically verify submitted information with reduced manual verifications.
- Collaborate with other intrastate agencies to adopt national standards for application of mass adjustments.

3.7.2.5.4 Scorecard

The following scorecard was compiled for the Apply Mass Adjustment business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
Claims Adjudication Apply Mass Adjustment	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		

Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.8 PERFORMANCE MANAGEMENT

OVERVIEW

The Performance Management business area is a collection of business processes involved in the assessment of program compliance (e.g., auditing and tracking medical necessity and appropriateness of care, quality of care, patient safety, fraud and abuse, erroneous payments, and administrative anomalies). This business area uses information about an individual provider or member (e.g., demographics, information about the case itself such as case manager ID, dates, actions, and status, and information about parties associated with the case) and uses this information to perform functions related to utilization and performance. The Performance Management business area is responsible for the business activity and compliance data stores.

The Performance Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.8-1.

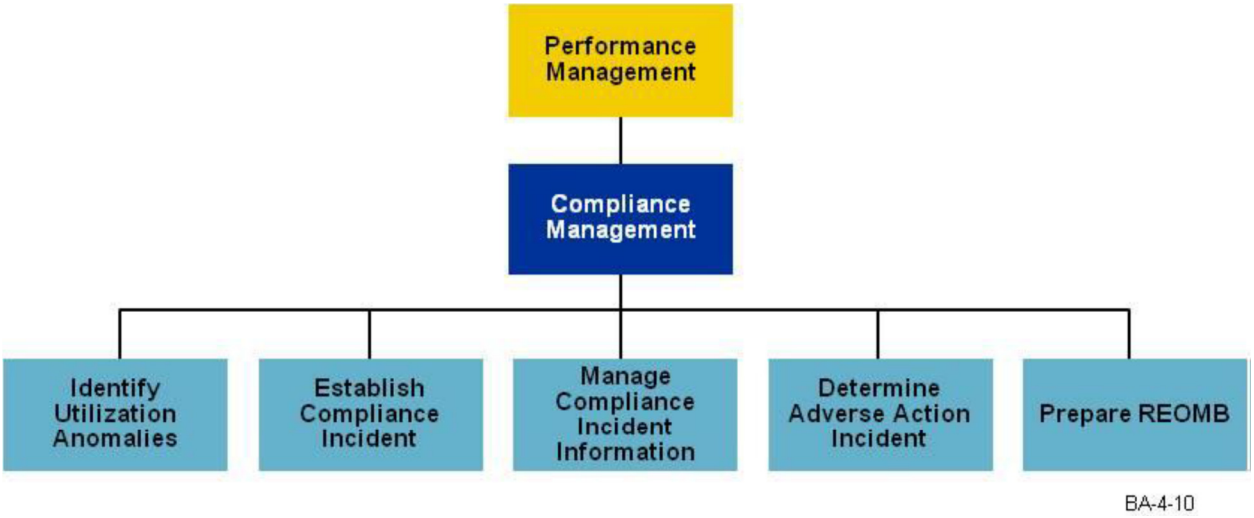


Figure 3.8-1

BUSINESS ARCHITECTURE PROFILE

The Performance Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Performance Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Identify Utilization Anomalies		As-Is	To-Be		
Establish Compliance Incident		As-Is	To-Be		

Manage Compliance Incident Information		As-Is	To-Be		
Determine Adverse Action Incident	As-Is		To-Be		
Prepare REOMB		As-Is	To-Be		

3.8.1 Compliance Management

As shown in Figure 3.8-1, the Compliance Management business category is made up of four business processes:

- Identify Utilization Anomalies
- Establish Compliance Incident
- Manage Compliance Incident Information
- Determine Adverse Action Incident
- Prepare REOMB

Details regarding the assessment of each Member Enrollment business process follow.

3.8.1.1 Identify Utilization Anomalies

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Identify Utilization Anomalies business process.

3.8.1.1.1 Business Process Model

The Identify Utilization Anomalies business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PE Compliance Management		
Identify Utilization Anomalies		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Identify Utilization Anomalies*** business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable and unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Internal and external referrals, business intelligence	Program Integrity addresses providers, members and contractors.

PE Compliance Management		
Identify Utilization Anomalies		
Item	**Details**	**DMAS Differences/Comments**
	analysis (i.e., historical, current, and predictive views of business operations), and scheduled or on-demand reporting may identify a compliance incident. Identification of utilization anomalies include evaluation of: • Provider utilization review • Provider compliance review • Contractor utilization review (includes managed care organizations) • Contractor compliance review • Member utilization review • Investigation of potential fraud or abuse review • Drug utilization review • Quality review (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures) • Performance review (e.g., Key Performance Indicator (KPI)) • Erroneous payment • Contract review • Audit Review • Other evaluation of information Different criteria and rules, relationships, and information define each type of compliance incident and require different types of external investigation.	DMAS performs reviews consistent with PERM (Payment and Error Rate Measurement) and MEQC (Medicaid Eligibility Quality Control) requirements
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive alert sent from business process that has outliers from established benchmarks. Environment-based Trigger Events to include but not limited to: • Periodic timetable is due to scan for compliance incidents. • Request to examine a specific group, individual, or other entity.	Many referrals received from local DSS offices and others (about 2,000 recipient referrals per year) MCOs may send an alert

PE Compliance Management		
Identify Utilization Anomalies		
Item	**Details**	**DMAS Differences/Comments**
		based on its review
Result	• Identification of utilization anomalies. • If applicable, alert sent to notify member via ***Manage Applicant and Member Communication*** business process with anomaly information. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process with anomaly information. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process with anomaly information. • If applicable, alert sent to ***Establish Compliance Incident*** business process for further investigation and monitoring. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request or reach scheduled timetable review 2. Review performance measures and benchmark targets. 3. Define characteristics of the target group in which the analysis will focus: types of provider, location, types of services, member characteristics, medical conditions. 4. Identify information requirements, both selection parameters and reporting parameters to include items such as time period(s), data elements, data relationships. 5. Identify rules to apply to the information — Select or create rules including specified norms, statistical deviations, types of patterns, Boolean logic, ratios, percentages. 6. Apply rules to targeted group information.	

PE Compliance Management		
Identify Utilization Anomalies		
Item	**Details**	**DMAS Differences/Comments**
	7. Record the results. 8. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process with anomaly information. 9. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process with anomaly information. 10. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process with anomaly information. 11. **END:** If applicable, send alert to the ***Establish Compliance Incident*** business process for further investigation and monitoring.	
Shared Data	Member data store including demographics, eligibility, enrollment, and grievance information Provider data store including provider network, contract, and grievance information Contractor data store including provider network, and contract information Care Management data store including member health status, clinical data, and treatment outcome information Claims data store including payment information Financial data store including accounts receivable and accounts payable information Compliance Management data store including compliance incident information	Includes DSS recipient information; use PARIS to determine if a member is receiving benefits in another state Do not have general access to member and provider grievance information Do not have Care Management data Do not have access to financial data There is not a single source of information

PE Compliance Management		
Identify Utilization Anomalies		
Item	**Details**	**DMAS Differences/Comments**
		regarding compliance management data, such as those performed by contractors
Predecessor	***Manage Performance Measures***	
Successor	***Establish Compliance Incident*** ***Manage Business Relationship Communication*** ***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication***	
Constraints	States and programs within States establish different criteria for their investigations. Rules change along with the experience of the state, health care industry best practices, modifications in benefits, or with the addition of new provider types.	
Failures	• Staff is unable to identify target population because of insufficient information.	Unable to access needed information
Performance Measures	• Time to complete the process = within ___hours, ___minutes • Compliance Incident resulting in corrective action, settlement, or collection =__%	Time to complete: N/A Compliance: N/A (suspect rate is about 90% for members; 95+% for provider)

3.8.1.1.2 As-Is Assessment

The overall rating for the Identify Utilization Anomalies business process is '2'. DMAS has multiple sources of information regarding compliance management data, such as those performed by contractors. Data is stored in different systems.

Other items noted in the As-Is assessment were:

- Member data store includes DSS recipient information; use PARIS to determine if a member is

receiving benefits in another state.
- DMAS performs reviews consistent with PERM (Payment and Error Rate Measurement) and MEQC (Medicaid Eligibility Quality Control) requirements.

3.8.1.1.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Identify Utilization Anomalies business process:

- Establish performance targets and meaningful metrics to track timeliness and results of the business process.
- Implement automated business rules for decision making.
- Automate process steps that result in data collection from different systems.
- Provide greater access to data to qualified business stakeholders.

3.8.1.1.4 Scorecard

The following scorecard was compiled for the Identify Utilization Anomalies business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PE – Compliance Management Identify Utilization Anomalies	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3

Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.8.1.2 Establish Compliance Incident

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Identify Utilization Anomalies business process.

3.8.1.2.1 Business Process Model

The Establish Compliance Incident business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PE Compliance Management		
Establish Compliance Incident		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Establish Compliance Incident*** business process is responsible registration of a case for incident tracking of utilization anomalies. It establishes an incident file, generates incident identification, assigns an incident manager, links to related cases, and collects related documentation.	
Trigger Event	Incident-based Trigger Events: Receive alert to establish incident tracking from	

PE Compliance Management		
Establish Compliance Incident		
Item	**Details**	**DMAS Differences/Comments**
	Identify Utilization Anomalies business process. Receive alert to establish incident tracking from ***Manage Member Grievance and Appeal*** business process. Receive alert to establish incident tracking from ***Manage Provider Grievance and Appeal*** business process. Receive alert to establish incident tracking from ***Manage Contractor Grievance and Appeal*** business process. Environment-based Trigger Events to include but not limited to: Request to initiate incident tracking for business partner, member, provider, contractor or other entity. Request to initiate incident from communication (e.g., mail, telephone, facsimile or web). Receive requests for suppression of information or corrective action from federal and state law enforcement. Receive compliance investigation information from Centers for Medicare & Medicaid Services (CMS). • Receive compliance investigation information from Medicaid Fraud Control Unit (MFCU). • Receive compliance investigation information from Office of Inspector General (OIG).	Member incidents not created based on grievance and appeals Incidents can be identified due to information uncovered through a variety of internal DMAS processes

PE Compliance Management		
Establish Compliance Incident		
Item	**Details**	**DMAS Differences/Comments**
	• Receive self-disclosure of actual or potential violations from provider.	
Result	• Initiation of a compliance incident. • Alert sent to ***Manage Compliance Incident Information*** business process for incident monitoring. • If applicable, notification sent to state or federal law enforcement agencies of possible criminal investigation. • If applicable, notification sent to CMS of compliance investigation. • If applicable, notification sent to MFCU of compliance investigation. • If applicable, notification sent to OIG of compliance investigation. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Request to establish incident tracking. 2. Establish incident case with required information. 3. Generate incident identification. 4. Assign and authorize an incident manager to manage an incident and request additional information. 5. Identify and link related incidents to this one.	May be linked by data element values, such as allegation type.

PE Compliance Management		
Establish Compliance Incident		
Item	**Details**	**DMAS Differences/Comments**
	6. Collect relevant documentation. 7. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation. 8. If applicable, send notification to CMS of compliance investigation. 9. If applicable, send notification to MFCU of compliance investigation. 10. If applicable, send notification to OIG of compliance investigation. 11. **END:** Send alert to ***Manage Compliance Incident Information*** business process for incident monitoring.	
Shared Data	Member data store including demographics, eligibility, enrollment, and grievance information Provider data store including provider network, contract, and grievance information Contractor data store including provider network, and contract grievance information Claims data store including payment information Financial data store including accounts receivable and accounts payable information Business Activity data store including performance information Compliance Management data store including compliance incident information	
Predecessor	***Identify Utilization Anomalies***	

PE Compliance Management		
Establish Compliance Incident		
Item	**Details**	**DMAS Differences/Comments**
	Manage Member Information ***Manage Provider Information*** ***Manage Contractor Information***	
Successor	***Manage Compliance Incident Information***	
Constraints	States and programs within States establish different criteria for their investigations. Rules change along with the experience of the state, health care best practices, modifications in benefits, and with the addition of new provider and member types.	
Failures	• No incident tracking requests made. • Lack of required information to establish an incident.	
Performance Measures	• Time to complete the process = e.g.,__ days, ___hours or __minutes • Accuracy with which rules are applied = ___% • Consistency with which rules are applied = ___% • Error rate = ___% or less	There are no specific performance measures but cases are handled on a priority basis when needed and standard processes followed

3.8.1.2.2 As-Is Assessment

The overall rating for the Establish Compliance Incident business process is '2'. The process follows a mix of manual and automatic programs.

Other items noted in the As-Is assessment were:

- DMAS does not create member incidents based on grievance and appeals.
- Incidents can be identified due to information uncovered through a variety of internal DMAS processes.

3.8.1.2.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Establish Compliance Incident business process:

- Establish performance targets and meaningful metrics to track timeliness, accuracy, consistency and error rate of the business process.
- Collaborate with federal and state law enforcement and CMS data sources to automate the exchange of data to the full extent possible.
- Use standardized business rules to automate decision making in the process.
- Maintain an audit trail of decisions 100% of the time.

3.8.1.2.4 Scorecard

The following scorecard was compiled for the Establish Compliance Incident business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PE – Compliance Management Establish Compliance Incident	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		

Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.8.1.3 Manage Compliance Incident Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Compliance Incident Information business process.

3.8.1.3.1 Business Process Model

The Manage Compliance Incident Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PE Compliance Management		
Manage Compliance Incident Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Compliance Incident Information*** business process is responsible for the monitoring of incidents of utilization anomalies. Activities include referring (e.g., escalation) incident to another incident manager or agency, modifications to incident information, journaling activities, and disposition of incident.	

PE Compliance Management		
Manage Compliance Incident Information		
Item	**Details**	**DMAS Differences/Comments**
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive alert from ***Establish Compliance Incident*** business process of new incident. Environment-based Trigger Events to include but not limited to: • Staff periodically reviews incident. • Staff modifies incident information due to follow-up activities. • Receive requests for suppression of information or corrective action from federal and state law enforcement. • Receive compliance investigation information from Centers for Medicare & Medicaid Services (CMS). • Receive compliance investigation information from Medicaid Fraud Control Unit (MFCU). • Receive compliance investigation information from Office of Inspector General (OIG). • Receive self-disclosure of actual or potential violations from provider.	
Result	• Monitored incident and tracked. • Determination of disposition and closure	

PE Compliance Management		
Manage Compliance Incident Information		
Item	**Details**	**DMAS Differences/Comments**
	of incident. • If applicable, alert sent to notify member via ***Manage Applicant and Member Communication*** business process of incident tracking information. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of incident tracking information. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of incident tracking information. • If applicable, alert sent to ***Determine Adverse Action Incident*** business process for further investigation. • If applicable, notification sent to state or federal law enforcement agencies of possible criminal investigation. • If applicable, notification sent to CMS for compliance investigation. • If applicable, notification sent to MFCU of compliance investigation. • If applicable, notification sent to OIG of compliance investigation. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process	1. **START:** Receive established incident. 2. Review incident information for	

PE Compliance Management		
Manage Compliance Incident Information		
Item	**Details**	**DMAS Differences/Comments**
Steps	determination of action. 3. Review allegations. 4. If applicable, refer or escalate incident to responsible individual, department or state or federal agency. 5. Determine action to take (e.g., journal entry, appointment scheduling, research, communication). 6. Perform appropriate action. 7. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process of incident tracking information. 8. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process of incident tracking information. 9. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of incident tracking information. 10. Determine disposition of incident. 11. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation. 12. If applicable, send notification to CMS for compliance investigation. 13. If applicable, send notification to MFCU of compliance investigation.	

PE Compliance Management		
Manage Compliance Incident Information		
Item	**Details**	**DMAS Differences/Comments**
	14. If applicable, send notification to OIG of compliance investigation. 15. If applicable, send alert to ***Determine Adverse Action Incident*** business process for further investigation. 16. **END:** Close incident.	
Shared Data	Member data store including demographics, eligibility, enrollment, and grievance information Provider data store including provider network, contract, and grievance information Contractor data store including provider network, and contract information Claims data store including payment information Financial data store including accounts receivable and accounts payable information Business Activity data store including performance information Compliance Management data store including compliance incident information	
Predecessor	***Establish Compliance Incident*** ***Maintain State Plan***	
Successor	***Manage Applicant and Member Communication*** ***Manage Provider Communication*** ***Manage Contractor Communication***	

PE Compliance Management		
Manage Compliance Incident Information		
Item	**Details**	**DMAS Differences/Comments**
	Determine Adverse Action Incident ***Manage Data***	
Constraints	States and programs within States establish different criteria for their investigations. Rules change along with the experience of the state, health care best practices, modifications in benefits, and with the addition of new provider and member types	
Failures	• This business process has no failure modes that prevent the process from completion.	
Performance Measures	• Time to complete the process = e.g.,___ days,__hours or ___minutes • Accuracy with which rules are applied = ___% • Consistency with which rules are applied = ___% • Error rate = ___% or less	Initiate review within 30 days Accuracy = 100% Consistency = 100% Error = 0%

3.8.1.3.2 As-Is Assessment

The overall rating for the Manage Compliance Incident Information business process is '2'. At DMAS within the Program Integrity Division, we are able to share data through some of our systems, we do have the ability to share systems with other entities that also manage complaints/compliance, such as our contractors that perform compliance reviews, as well other state entities that look at compliance, such as the Medicaid Fraud Control Unit (MFCU) at the Office of the Attorney General, or the Department of Health, to a name a few. However, Level 3 could not be met because we are not fully integrated with these other entities to include state/federal entities.

Other items noted in the As-Is assessment were:

- The business process Management of Compliance Incidents is performed in accordance to established internal standards. The Recipient Monitoring Unit at DMAS, which handles the

Client Medical Management Program- a member utilization review program, operates in according to the standards outlined in the Recipient Monitoring Unit Operating Manual.

- The Recipient Audit Unit (RAU) at DMAS, which performs investigations and audits of member based incidents of fraud, waste, and abuse, conducts investigations and reviews in compliance with the RAU Operating Procedures Manual. Both of these documents, blueprint the internal procedures followed by all incident managers.

3.8.1.3.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Manage Compliance Incident Information business process:

- Collaborate with federal and state law enforcement and CMS data sources to integrate and automate the exchange of data to the full extent possible.
- Reduce the time needed to initiate the review.
- Use standardized business rules to automate the process steps where cost effective.
- Maintain an audit trail of decisions 100% of the time.
- Establish performance targets and meaningful metrics to track timeliness, accuracy, consistency and error rate of the business process.

3.8.1.3.4 Scorecard

The following scorecard was compiled for the Manage Compliance Incident Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PE – Compliance Management Manage Compliance Incident Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	1	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		

Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	1	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.8.1.4 Determine Adverse Action Incident

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Determine Adverse Action Incident business process.

3.8.1.4.1 Business Process Model

The Determine Adverse Action Incident Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PE Compliance Management		
Determine Adverse Action Incident		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Determine Adverse Action Incident*** business process receives an incident from an investigative unit with the direction to pursue the case to closure. The case may result in civil	

PE Compliance Management		
Determine Adverse Action Incident		
Item	**Details**	**DMAS Differences/Comments**
	or criminal charges, corrective action, removal of a provider, contractor, trading partner or member from the Medicaid Program, or the State Medicaid Agency (SMA) may terminate or suspend the case. Individual state policy determines what evidence is necessary to support different types of cases: Provider utilization review Provider compliance review Contractor utilization review (includes managed care organizations) Contractor compliance review Member utilization review Investigation of potential fraud or abuse review Drug utilization review Quality review (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures) • Performance review (e.g., Key Performance Indicator (KPI)) Contract review Erroneous payment review Audit Review Other evaluation of information	CAPHIS not used by provider compliance

PE Compliance Management		
Determine Adverse Action Incident		
Item	**Details**	**DMAS Differences/Comments**
	Different criteria and rules, relationships, and information define each type of adverse action incident and require different types of external investigation.	
Trigger Event	Interaction-based Trigger Events to include but not limited to: Receive alert from ***Manage Compliance Incident Information*** business process for further investigation. Environment-based Trigger Events to include but not limited to: Request to investigate adverse action incident. Receive requests for suppression of information or corrective action from federal and state law enforcement. Receive compliance investigation information from Centers for Medicare & Medicaid Services (CMS). Receive compliance investigation information from Medicaid Fraud Control Unit (MFCU). Receive compliance investigation information from Office of Inspector General (OIG). • Receive self-disclosure of actual or potential violations from provider.	
Result	Monitored adverse action incident and tracked activities. Determination of disposition and closure of incident. If applicable, alert sent to notify member via	

PE Compliance Management		
Determine Adverse Action Incident		
Item	**Details**	**DMAS Differences/Comments**

	Manage Applicant and Member Communication business process of incident tracking information.
	
	If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of incident tracking information.
	
	If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of incident tracking information.
	
	If applicable, alert sent to ***Disenroll Member*** business process to remove member from services.
	
	If applicable, alert sent to ***Disenroll Provider*** business process to remove provider from services.
	
	If applicable, alert sent to ***Terminate Provider*** business process to cease activities with provider.
	
	• If applicable, alert sent to ***Close Out Contract*** business process to cease activities with contractor.
	
	  • If applicable, notification sent to state or federal law enforcement agencies of possible criminal investigation.
	
	  • If applicable, notification sent to CMS for compliance investigation.
	
	  • If applicable, notification sent to MFCU of compliance investigation.
	
	  • If applicable, notification sent to OIG of compliance investigation.	

PE Compliance Management		
Determine Adverse Action Incident		
Item	**Details**	**DMAS Differences/Comments**
	• Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request to investigate adverse action incident. 2. Assign and authorize an adverse action incident manager to manage an incident and request additional information. 3. Establish adverse action incident case with required information. 4. Examine information associated with the case, and request more historical information as needed. 5. Determine action to take (e.g., journal entry, appointment scheduling, research, communication). 6. Perform appropriate action. 7. Correspond with providers, members, agents, guardians, attorneys, and others to notify them regarding the investigation, their rights, and the right of the SMA to request documentation. 8. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process of incident tracking information. 9. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process of incident tracking information.	

PE Compliance Management		
Determine Adverse Action Incident		
Item	**Details**	**DMAS Differences/Comments**
	10. If applicable, send sent to notify contractor via ***Manage Contractor Communication*** business process of incident tracking information. 11. Conduct inquiries and investigations. Depending on the type of case, the SMA may need to conduct different external inquiries (e.g., view medical records, interview members, validate credentials). 12. Document evidence as required. 13. When research and analysis are complete, report the case disposition (e.g., cancel incident, claim damages, identify corrective action, suspend or terminate participation in Medicaid Program). 14. If applicable, send alert to ***Disenroll Member*** business process to remove member from services. 15. If applicable, send alert to ***Disenroll Provider*** business process to remove provider from services. 16. If applicable, send alert to ***Terminate Provider*** business process to cease activities with provider. 17. If applicable, send alert to ***Close Out Contract*** business process to cease activities with contractor. 18. If applicable, send notification to state or federal law enforcement agencies of possible criminal investigation.	

PE Compliance Management		
Determine Adverse Action Incident		
Item	**Details**	**DMAS Differences/Comments**
	19. If applicable, send notification to CMS for compliance investigation. 20. If applicable, send notification to MFCU of compliance investigation. 21. If applicable, send notification to OIG of compliance investigation. 22. **END:** Close adverse action incident.	
Shared Data	Member data store including demographics, eligibility, enrollment, and grievance information Provider data store including provider network, contract, and grievance information Contractor data store including provider network, and contract information Claims data store including payment information Financial data store including accounts receivable and accounts payable information Business Activity data store including performance information Compliance Management data store including compliance incident information	No general access to member and provider grievance information
Predecessor	***Establish Compliance Incident***	
Successor	***Manage Applicant and Member Communication*** ***Manage Provider Communication***	Financial recovery may be requested

PE Compliance Management		
Determine Adverse Action Incident		
Item	**Details**	**DMAS Differences/Comments**
	Manage Contractor Communication ***Disenroll Member*** ***Disenroll Provider*** ***Terminate Provider*** ***Close Out Contract***	
Constraints	States and programs within States establish different criteria for their investigations. Rules change along with the experience of the state, health care best practices, modifications in benefits, and with the addition of new provider and member types.	
Failures	• No request to investigate adverse action incident received. • Ceased incident without reaching disposition.	
Performance Measures	• Time lag between request for documents and receipt = ___Days, ___Hours • Time to bring a case to closure = ___Months, ___Weeks • Number of cases that the agency is able to close within designated time period = ___ • Percent cases closed without grievance or appeal =___%	Expectation is 10 (member) -14 (provider) days N/A (depends on size and circumstances) N/A across PI - 81 for Provider % w/o grievance and appeal is tracked in each area

3.8.1.4.2 As-Is Assessment

The overall rating for the Determine Adverse Action Incident Information business process is '1'. The process is dependent on other entities for some information, thus reducing timeliness and efficiency of the process.

Other items noted in the As-Is assessment were:

- DMAS does not have a general access to member and provider grievance information and CAPHIS does not utilize provider compliance.
- Financial recovery may be requested as a result of performing the business process.

3.8.1.4.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Determine Adverse Action Incident Information business process:

- Improve efficiency, data access and accuracy by collaborating with federal and state law enforcement and CMS to integrate with their data stores and other regional hubs.
- Reduce lag time between request for documents and receipt by integrating with federal and state law enforcement and CMS data sources.
- Use standardized business rules to automate the exchange of data and other process steps where cost effective.
- Maintain an audit trail of decisions 100% of the time.
- Utilize electronic surveys and/or questionnaires to determine the level of stakeholder satisfaction in the business process.
- Establish performance targets and meaningful metrics to track timeliness, accuracy, consistency and error rate of the business process.

3.8.1.4.4 Scorecard

The following scorecard was compiled for the Determine Adverse Action Incident business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PE – Compliance Management Determine Adverse Action Incident	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	1	3
Timeliness of Process	1	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	1	3
Performance Measure		

Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	1	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.8.1.5 Prepare REOMB

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Prepare REOMB business process.

3.8.1.5.1 Business Process Model

The Prepare REOMB Incident Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PE Compliance Management		
Prepare REOMB		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Prepare REOMB*** business process is responsible for the creation of Recipient Explanation of Medicaid Benefits (REOMB) for	A variety of services are excluded from the

PE Compliance Management		
Prepare REOMB		
Item	**Details**	**DMAS Differences/Comments**
	detecting payment problems. The State Medicaid Agency (SMA) sends the REOMB to randomly selected members of Medicaid services. It gives information on the Medicaid services paid on behalf of the member. The communication includes the provider's name, the date(s) of services, and the payment amount(s). Instructions on the communication tell the member what to do if the provider did not actually perform any of the listed services billed directly to him/her by the provider. **NOTE:** This business process does not include the handling of returned information.	REOMB.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic timetable is due for generation of the REOMB sample information.	Performed monthly
Result	• Member receives REOMB. • Alert sent with REOMB notification to member via ***Manage Applicant and Member Communication*** business process with REOMB information. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Timetable for scheduled REOMB generation. 2. Identify member selection using random sampling methodology. 3. Review sample selection information. 4. Prepare REOMB for each select member.	

PE Compliance Management		
Prepare REOMB		
Item	**Details**	**DMAS Differences/Comments**
	5. **END:** Send alert to member via ***Manage Applicant and Member Communication*** business process with REOMB information.	
Shared Data	Member data store including demographics information Claims data store including payment information	
Predecessor	None	
Successor	***Manage Applicant and Member Communication***	
Constraints	The policies and business rules for preparing the REOMB sample information differ by state. The SMA will provide the REOMB or letters to the members within 45 days of payment of claims.	REOMBs are for previous month based on data of payment.
Failures	• This business process has no failure modes that prevent the process from going to completion.	
Performance Measures	• Time to complete process: e.g., Batch Responses = within ___hours • Error rate = ___% or less	The REOMBs are produced on the same day of each calendar month

3.8.1.5.2 As-Is Assessment

The overall rating for the Prepare REOMB Information business process is '2'. There is very little collaboration in performing the business process, effectiveness is near 75% since capability to enhance sampling is not used to the full extent possible.

One other item noted in the As-Is assessment was:

- DMAS produces REOMB for previous month on the same day of each calendar month based on data of payment.

3.8.1.5.3 To-Be Assessment

The following areas of possible improvement noted in the Business Process Model and Business Capability Model will allow DMAS to reach a Level 3 rating for the Prepare REOMB Information business process:

- Integrate the REOMB process with Personal Health Records (PHR) to enhance the sampling process.
- Use standardized business rules to automate the generation of REOMBs.
- In addition to targeted populations, generate the sampling dynamically based on provider billing patterns and SURS results.
- Provide members with the option to review and report on questionable services using the DMAS web portal or other web application.
- Establish performance targets and meaningful metrics to track timeliness, accuracy, consistency and error rate of the business process.

3.8.1.5.4 Scorecard

The following scorecard was compiled for the Prepare REOMB business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PE – Compliance Management Prepare REOMB	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	1	3
Performance Measure		

Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.9 PLAN MANAGEMENT

OVERVIEW

The Plan Management business area includes the strategic planning, policymaking, monitoring, and oversight business processes of the agency. This business area is responsible for the primary data stores (e.g., Medicaid State Plan, health plans and health benefits) as well as performance measures, reference information, and rate setting data stores. The business processes includes a wide range of planning, analysis, and decision-making activities. These activities include service needs and goals, health care outcome targets, quality assessment, performance and outcome analysis, and information management.

As the Medicaid Enterprise mature, Plan Management benefits from immediate access to information, addition of clinical records, use of nationally recognized standards, and interoperability with other programs. The Medicaid Program is moving from a focus on daily operations (e.g., number of claims paid) to a strategic focus on how to meet the needs of the population within a prescribed budget.

The Plan Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.9-1.

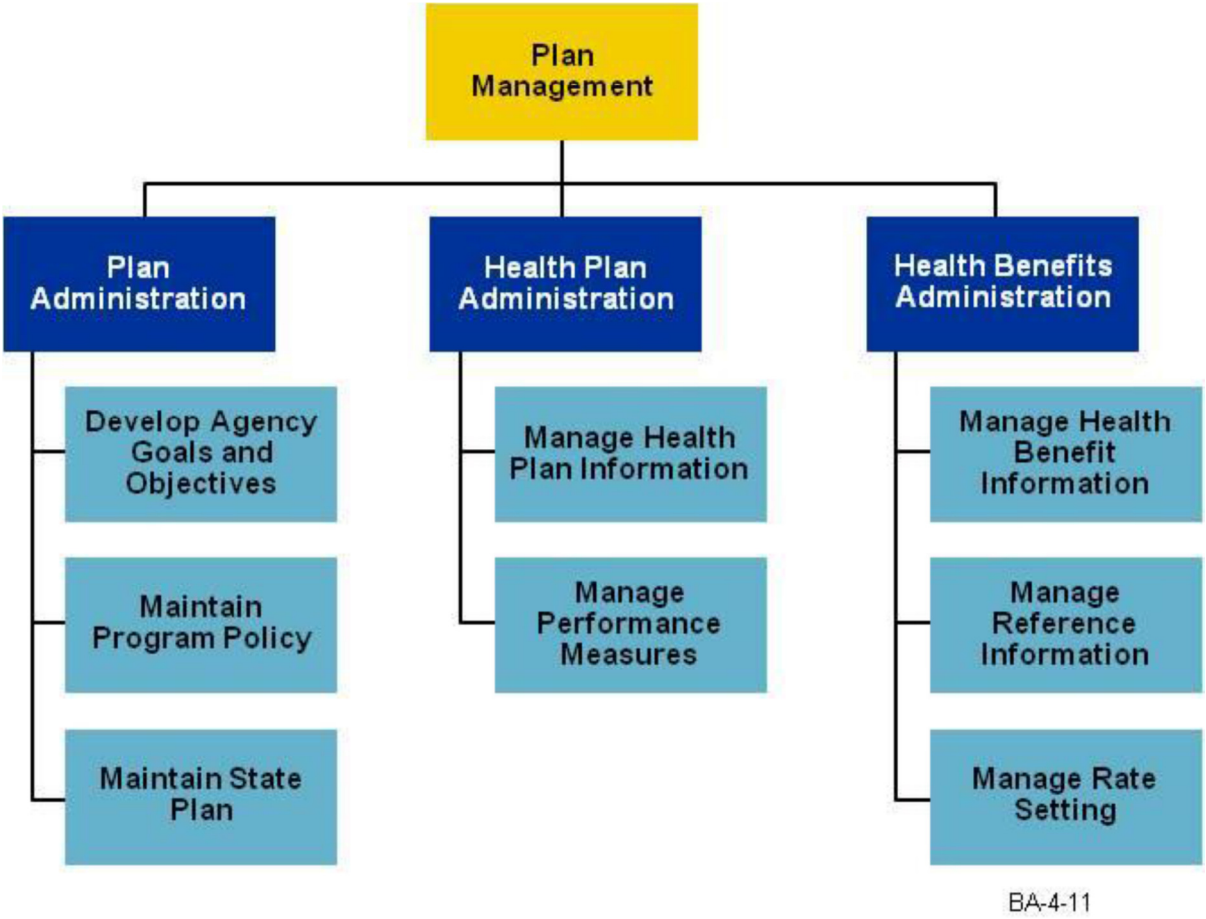


Figure 3.9-1

BUSINESS ARCHITECTURE PROFILE

The Plan Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Plan Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Develop Agency Goals and Objectives		As-Is	To-Be		
Maintain Program Policy	As-Is	To-Be			
Maintain State Plan		As-Is	To-Be		
Manage Health Plan Information		As-Is	To-Be		
Manage Performance Measures		As-Is	To-Be		
Manage Health Benefit Information		As-Is	To-Be		
Manage Reference Information		As-Is	To-Be		
Manage Rate Setting		As-Is	To-Be		

3.9.1 Plan Administration

As shown in Figure 3.9-1, the Plan Administration business category is made up of following three business processes:

- Develop Agency Goals and Objectives
- Maintain Program Policy
- Maintain State Plan

Details regarding the assessment of each Plan Administration business process follow.

3.9.1.1 Develop Agency Goals and Objectives

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Develop Agency Goals and Objectives business process.

3.9.1.1.1 Business Process Model

The Develop Agency Goals and Objectives business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PL Plan Administration		
Develop Agency Goals and Objectives		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Develop Agency Goals and Objectives*** business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary. Goals and objectives may warrant change for example, under a new administration, in response to changes in demographics, public opinion or medical industry trends, or in response to regional or national disasters.	A DMAS Strategic Plan is developed every two years. The agency goals and initiatives are based on the Strategic Plan, which is driven down from higher sources outside the agency. <u>Strategic Plan</u> 1. Virginia Road Map – State level goals done by a steering committee. 2. Governor's Key Objectives 3. State Agency Strategic Plan – supports the overall goals of the higher plans. 4. Division Level Strategic Plan –rolls up support the State Agency Strategic Plan. This is a long-term planning process not a short-term tool. Changes in administrations do not affect this process. Changes in demographic or public options would be part of the annual refinement process. Mission statement usually changes with administration. Timelines and directives for this process come from the Governor's Office with the DPB serving as a facilitator. Once complete, the agency's plan is submitted via a web portal to the Governor's Office. Documentation provided by DPB gives guidance for this process. The

PL Plan Administration		
Develop Agency Goals and Objectives		
Item	**Details**	**DMAS Differences/Comments**
		documentation provides an overall process structure including instructions for using the SWOT tool for the agency's assessment and instructions for using the web portal for inputting and updating the plan. This documentation can be found on DPB's web site: http://www.dpb.virginia.gov/sp/sp.cfm The Project Management Standard (CPM 112-03.2) which includes information on the use of CTP (IT Portfolio Management Tool) is available on the VITA Policy, Standards and Guidelines (PSG) Web page at http://www.vita.virginia.gov/library/default.aspx?id=537 and can link goals and objects to projects undertaken.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., annual) is due for review of goals and objectives. • Periodic timetable (e.g., annual) is due to implement new goals or objectives. • Ad hoc request for goals or objectives updates.	This process is primarily addressed on an ad hoc basis for DMAS.

PL Plan Administration		
Develop Agency Goals and Objectives		
Item	**Details**	**DMAS Differences/Comments**
Result	• The State Medicaid Agency (SMA) defines new or modified statement of goals or objectives. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START.** Receive notice that the SMA requires a review of current goals and objectives or the review interval is due. 2. Review existing goals, objectives, and priorities. 3. Review information such as current performance measurements, industry successes, budget, and other States/programs successes. 4. Convene Stakeholders. 5. Develop consensus on changes and priorities. 6. **END**. Publish new or revised statement of goals and objectives, including performance measurements and priorities.	Policy & Research may perform analysis of regulations, other states' activities, relevant literature, etc., and prepare a decision brief.
Shared Data	Plan data store including Medicaid State Plan, health plan, health benefits, performance measures, and benchmarks information Business Activity data store including performance information (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)	

PL Plan Administration		
Develop Agency Goals and Objectives		
Item	**Details**	**DMAS Differences/Comments**
Predecessor	***Manage Performance Measures***	
Successor	***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Maintain Program Policy*** ***Maintain State Plan*** ***Manage Performance Measures***	
Constraints	Economic conditions shift, making less revenue available to fund the approved and planned budget. The State Medicaid Agency will comply with federal and state regulations.	
Failures	• Stakeholders are unable to reach consensus on the SMA goals and objectives.	
Performance Measures	• Time to complete the process = within days,_____weeks • Achievement of goals and objectives linked to policy implementation	This varies on specific goal/objective to be implemented.

3.9.1.1.2 As-Is Assessment

The overall rating for the Develop Agency Goals and Objectives business process is '2'. The process is largely manual although DMAS uses standards defined for the process and automated tools to improve data access, such as a web portal to submit its strategic plan.

Other items noted in the As-Is assessment were:

- A change in administration does not have any impact on the Develop Agency Goals and Objectives business process. However, the mission statement is adjusted with any changes in the administration.
- This process is primarily a manual process that is performed every two years or as needed. Automation, such as SAS, is used to gather and analyze information. Operational activities can be traced to goals and objectives.

3.9.1.1.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Develop Agency Goals and Objectives business process.

Specific changes identified include:

- Automating the Develop Agency Goals and Objectives business process to the fullest extent possible in a cost-effective manner, including increased automation of information collection
- Using brainstorming and automatic collaboration tools that enable statewide input to the goal setting process.
- Using business intelligence tools to monitor progress toward benchmarks
- Ensuring goals and objectives are central, up-to-date and accurate
- Identifying and tracking performance measures and using them to identify process improvements.

3.9.1.1.4 Scorecard

The following scorecard was compiled for Develop Agency Goals and Objectives business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PL – Plan Administration ***Develop Agency Goals and Objectives***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	1	2
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		

Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.9.1.2 Maintain Program Policy

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Maintain Program Policy business process.

3.9.1.2.1 Business Process Model

The Maintain Program Policy business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PL Plan Administration		
Maintain Program Policy		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Maintain Program Policy*** Business Process responds to requests or needs for change in the	Program Policy is codified in the State

PL Plan Administration		
Maintain Program Policy		
Item	**Details**	**DMAS Differences/Comments**
	enterprise's programs, benefits, or business rules, based on factors such as federal or state regulations, governing board or commission directives, Quality Improvement Organization's findings, federal or state audits, enterprise decisions, or consumer pressure.	Plan, state and federal regulations, Medicaid manuals, waivers, and contracts.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., annual) is due for review of program policy. • Periodic timetable (e.g., annual) is due to implement new program policy or modification. • Ad hoc request for program policy updates.	There are periodic legislative reports to assess policy performance. Joint commissions, e.g., JLARC, may request reports. Policies may be reviewed based on regulations, legislation, provider group input, etc.
Result	• The State Medicaid Agency (SMA) defines new or modified statement of program policy. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START**: Receive request to add, delete, or change policy. 2. Request information to analyze policy. 3. Assess impact of policy on budget,	

PL Plan Administration		
	Maintain Program Policy	
Item	**Details**	**DMAS Differences/Comments**
	stakeholders, and other benefits. 4. Formulate and publish policy. 5. Hold public hearings. 6. Revise policy. 7. Seek all federal and state administrative and regulatory approvals. 8. If applicable, assess impact of requested revisions. 9. Determine effective date and date span for policy in coordination with other enterprise considerations. 10. If applicable, develop training plan for new policy. 11. Develop implementation plan for policy. 12. **END**: Disseminate policy.	12. Includes Medicaid Memos, decision papers, etc.
Shared Data	Plan data store including Medicaid State Plan, health plan, health benefits, performance measures, and benchmarks information Business Activity data store including performance information (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)	
Predecessor		

PL Plan Administration		
Maintain Program Policy		
Item	**Details**	**DMAS Differences/Comments**
	Develop Agency Goals and Objectives ***Manage Performance Measures*** ***Maintain State Plan***	
Successor	***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Maintain State Plan*** ***Manage Performance Measures*** ***Establish Business Relationship***	
Constraints	Economic conditions shift, making less revenue available to fund the approved and planned budget. The SMA will comply with federal and state regulations.	
Failures	• Cost/benefit analysis does not support proposed policy. • Inability to obtain necessary approvals.	
Performance Measures	• Time to complete the process = within days,____weeks • Achievement of goals and objectives linked to policy implementation	Dependent on type of change. Most State Plan Amendments need to be approved by CMS within 90 days

3.9.1.2.2 As-Is Assessment

The overall rating for the Maintain Program Policy business process is '1'. The business process is at Level 1 as there is no automation in place and it is a resource intensive process for DMAS.

Other items noted in the As-Is assessment were:

- DMAS can review policies on a need basis triggered by regulations, legislation, provider group input, etc.
- Following business process Maintain Program Policy could result in developing Medicaid memos and decision briefs.

3.9.1.2.3 To-Be Assessment

DMAS intends to achieve Level '2' functionality for the Maintain Program Policy business process.

Specific changes identified include:

- Automating the Maintain Program Policy business process to the fullest extent possible in a cost-effective manner, supplemented with manual processes as needed
- Using tools to gather, record, analyze, formulate, communicate, and distribute information on program policy to DMAS leadership and other state agencies
- Tracing some operational activities to program policy
- Begin using business intelligence tools to monitor progress toward benchmarks
- Ensuring program policy is up-to-date and accurate
- Identifying and tracking performance measures and using them to identify process improvements.

3.9.1.2.4 Scorecard

The following scorecard was compiled for Maintain Program Policy business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PL – Plan Administration Maintain Program Policy	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	1	2
Timeliness of Process	1	2
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	1	2

Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	1	2
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	2
Performance Measure		
Supporting Evidence Reference		

3.9.1.3 Maintain State Plan

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Maintain State Plan business process.

3.9.1.3.1 Business Process Model

The Maintain State Plan business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PL Plan Administration
Maintain State Plan

Item	Details	DMAS Differences/Comments
Description	The ***Maintain State Plan*** business process responds to the scheduled and unscheduled prompts to update and revise the Medicaid State Plan. The Medicaid State Plan is the officially recognized statement describing the nature and scope of the State Medicaid program as required under Section 1902 of the Social Security Act.	DMAS has both scheduled and unscheduled prompts to review the State Plan. Ad hoc reviews of the State Plan are based on legislative action and self-initiated regulation changes. A scheduled review is required every four years. Waiver programs, which are not included in the State Plan, do have periodic scheduled reviews every two years for cost effectiveness and renewal of the program.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., annual) is due for review of Medicaid State Plan. • Periodic timetable (e.g., annual) is due to implement new policy or modification. • Ad hoc request for Medicaid State Plan updates.	DMAS trigger events include legislative action, self-initiated regulation changes and the four year scheduled review.
Result	• The State Medicaid Agency (SMA) defines new or modified Medicaid State Plan. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive prompt or notification to review and update Medicaid State 2. Review relevant current Medicaid State Plan documentation. 3. Analyze requirements for change to Medicaid State Plan. 4. Research information associated with the change. 5. Analyze impact of the change and	DMAS typically performs steps 2 – 5 prior to legislation being passed. These steps are performed while the regulation is being discussed in the legislature. Virginia requires the regulation to be in place prior to the State Plan being updated. Work on the regulation cannot be retroactive, while updates to the State Plan can be retroactive.

PL Plan Administration		
	Maintain State Plan	
Item	**Details**	**DMAS Differences/Comments**
	determine whether to move forward with modification based on results of analysis: a. If no modifications to Medicaid State Plan are necessary, **END:** Business process stops. b. If necessary, request a waiver for submission in accordance with procedures from appropriate authorities. 6. Develop Medicaid State Plan modification. 7. Disseminate Medicaid State Plan modification for review, comment and approval by internal and external stakeholders. 8. Refine Medicaid State Plan modification based on feedback. 9. Conduct Medicaid State Plan Amendment (SPA) review process with CMS. 10. **END:** Publish Medicaid State Plan Amendment.	
Shared Data	Plan data store including Medicaid State Plan, health plan, health benefits, performance measures, and benchmarks information Business Activity data store including performance information	
Predecessor	***Develop Agency Goals and Objectives*** ***Maintain Program Policy***	

PL Plan Administration		
	Maintain State Plan	
Item	**Details**	**DMAS Differences/Comments**
	Manage Performance Measures ***Manage Budget Information***	
Successor	***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures*** ***Manage Applicant and Member Communication*** ***Perform Population and Member Outreach*** ***Manage Provider Communication*** ***Perform Provider Outreach*** ***Manage Contractor Communication*** ***Perform Contractor Outreach*** ***Manage Business Relationship Communication*** ***Manage Compliance Incident Information*** ***Formulate Budget*** ***Manage Data*** ***Establish Business Relationship***	
Constraints	Economic conditions shift, making less revenue available to fund the approved and planned budget.	

PL Plan Administration		
Maintain State Plan		
Item	**Details**	**DMAS Differences/Comments**
	The SMA will comply with federal and state regulations.	
Failures	• The SMA is unable to receive approval of Medicaid State Plan from internal or external stakeholders.	
Performance Measures	• Time to complete the process = within days, ____weeks • Achievement of goals and objectives linked to policy implementation	Varies based on change Performance measures are dictated by the Administrative Process Act. The State Plan must be submitted for approval to CMS within the quarter that the regulation is implemented.

3.9.1.3.2 As-Is Assessment

The overall rating for the Maintain State Plan business process is '2'. This process is primarily a manual process due to its nature, but generally meets the Level 2 capabilities. Automation, such as SAS, is used to gather and analyze information. DMAS meets expectations and schedules when maintaining its State Plan.

Other items noted in the As-Is assessment were:

- DMAS has both scheduled and unscheduled prompts to review the State Plan. Ad hoc reviews of the State Plan are based on legislative action and self-initiated regulation changes. A scheduled review is required every four years.
- DMAS requires the regulation to be in place prior to the State Plan being updated. Work on the regulation cannot be retroactive, while updates to the State Plan can be retroactive.

3.9.1.3.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Maintain State Plan business process.

Specific changes identified include:

- Automating the Maintain State Plan business process to the fullest extent possible in a cost-effective manner
- Using brainstorming and automatic collaboration tools that enable statewide input to Medicaid State Plan process.
- Using business intelligence tools to monitor progress toward benchmarks
- Tying all relevant operational activities to Medicaid State Plan within the intrastate
- Ensuring the Medicaid State Plan is central, up-to-date and accurate
- Identifying and tracking performance measures and using them to identify process improvements.

3.9.1.3.4 Scorecard

The following scorecard was compiled for Maintain State Plan business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PL – Plan Administration Maintain State Plan	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3

Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.9.2 Health Plan Administration

As shown in Figure 3.9-1, the Health Plan Administration business category is made up of two business processes:

- Manage Health Plan Information
- Manage Performance Measures

Details regarding the assessment of each Health Plan Administration business process follow.

3.9.2.1 Manage Health Plan Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Health Plan Information business process.

3.9.2.1.1 Business Process Model

The Manage Health Plan Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PL Health Plan Administration		
Manage Health Plan Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Health Plan Information*** business process includes evaluation of federal or state regulations, legislative and judicial mandates, federal or state audits governing board or	Health Plan Information is related to the variety of programs DMAS supports, such as Medicaid, Medallion 3.0, CCC, and waivers.

PL Health Plan Administration		
Manage Health Plan Information		
Item	**Details**	**DMAS Differences/Comments**
	commission directives, Quality Improvement Organization's findings, enterprise decisions, and consumer pressure to develop or enhance enterprise business rules, benefit plans and services available to members. The State Medicaid Agency (SMA) collaboratively develops Health Plan service offerings with input and review by other agencies and stakeholders. This business process ensures the organization is on track with the goals and objectives of the SMA and is in concert with statewide goals.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., annual) is due for review of policy. • Periodic timetable (e.g., annual) is due to implement new policy or modification. • Ad hoc request for program policy updates.	
Result	• The SMA defines new or modified policy. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Notification of legal or administrative mandates that have potential impact to Health Plan policy. 2. Analyze legal or administrative mandates and determine whether to create, revise, or terminate Health Plan policy. 3. Assess impact of policy on budget, stakeholders, and other benefits.	

PL Health Plan Administration		
Manage Health Plan Information		
Item	**Details**	**DMAS Differences/Comments**
	4. Create, revise, or terminate Health Plan policy and publish new, revised Health Plan policy, or notification of intent to terminate existing Health Plan policy. 5. Hold public hearings regarding Health Plan policy. 6. Revise Health Plan policy as necessary. 7. Submit Health Plan policy to federal and state administrative and regulatory agencies for approval. 8. Assess impact of requested revisions, if applicable. 9. Determine effective date and duration for Health Plan policy in coordination with other enterprise considerations. 10. Develop training plan for new, revised or discontinued Health Plan policy. 11. Develop implementation or transition plan for new, revised, or discontinued Health Plan policy. 12. Implement Health Plan policy. 13. **END:** Send Health Plan policy to Health Insurance Marketplace for certification.	
Shared Data	Financial data store including budget	

PL Health Plan Administration		
Manage Health Plan Information		
Item	**Details**	**DMAS Differences/Comments**
	information Member data store including demographic information Contractor data store including provider network information Provider data store including provider network information Plan data store including policy information Health Benefit data store including benefit program and benefit information Reference data store including code set information Authorization data store including authorization and treatment plan information Business Activity data store including performance information (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)	
Predecessor	***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Maintain State Plan*** ***Manage Health Benefit Information*** ***Manage Performance Measures*** ***Formulate Budget*** ***Manage Budget Information***	
Successor	***Manage Health Benefit Information*** ***Manage Reference Information*** ***Manage Rate Setting*** ***Manage Performance Measures***	

PL Health Plan Administration		
Manage Health Plan Information		
Item	**Details**	**DMAS Differences/Comments**
	Manage Applicant and Member Communication ***Perform Population and Member Outreach*** ***Manage Provider Communication*** ***Perform Provider Outreach*** ***Manage Contractor Communication*** ***Perform Contractor Outreach*** ***Manage Business Relationship Communication*** ***Establish Compliance Incident*** ***Manage Compliance Incident Information*** ***Formulate Budget*** ***Manage Data***	
Constraints	Economic conditions shift, making less revenue available to fund the approved and planned budget. The SMA will comply with federal and state regulations.	
Failures	• Cost/benefit analysis does not support proposed policy. • Inability to obtain necessary approvals.	
Performance Measures	• Time to complete the process = within days,__weeks • Achievement of goals and objectives linked to policy implementation	All programs are continuously monitored and analyzed for potential changes and to identify possible problems. The time to implement changes is dependent on priority and other factors.

3.9.2.1.2 As-Is Assessment

The overall rating for the Manage Health Plan Information business process is '2'. The process is a mix of manual and automated processes. MMIS databases are analyzed using SAS to evaluate current and proposed plans.

Other items noted in the As-Is assessment were:

- Health Plan Information is related to the variety of programs DMAS supports, such as Medicaid fee-for-service, Medallion 3.0, CCC, and waivers.
- DMAS continuously monitors all programs as they are further analyzed for potential changes and to identify possible problems. Implementation timeline for change to take effect is driven by the agency's priorities.

3.9.2.1.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Manage Health Plan Information business process.

Specific changes identified include:

- Automating the Manage Health Plan Information business process to the fullest extent possible in a cost-effective manner
- Sharing Health Plan information with the Health Insurance Marketplace (HIX)
- Adopting any relevant industry standards and information exchange with intrastate agencies
- Identifying and tracking performance measures and using them to identify process improvements.

3.9.2.1.4 Scorecard

The following scorecard was compiled for Manage Health Plan Information process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PL – Health Plan Administration Manage Health Plan Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3

Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.9.2.2 Manage Performance Measures

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Performance Measures business process.

3.9.2.2.1 Business Process Model

The Manage Performance Measures business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PL Health Plan Administration

Manage Performance Measures		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Performance Measures*** business process involves the design, implementation, and maintenance of mechanisms and measures the State Medicaid Agency (SMA) uses to monitor the business activities and performance of the State Medicaid Enterprise's business processes and programs. This includes the steps involved in defining the criteria by which the SMA measures activities and programs (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures). This business process develops the reports and other mechanisms that it uses to track activity and effectiveness at all levels of monitoring. Business Intelligence analysis (i.e., historical, current and predictive views of business operations) occurs within this process. Examples of performance measures and associated reports may be things such as: *Goal*: The SMA makes prompt and accurate payments to providers. *Measurement:* Pay or deny 95% of all clean claims within 30 days of receipt. *Mechanism:* The SMA generates weekly report on claims processing timelines. *Goal*: Accurately and efficiently, draw and report funds in accordance with the federal Cash Management Improvement Act (CMIA) and general cash management principles and timeframes to maximize non-general fund recovery. *Measurement:* Draw 98% of funds with the minimum time allowed under CMIA. *Mechanism*: The SMA generates monthly report on funds drawn. *Goal:* Improve health care outcomes for Medicaid members. *Measurement:* Reduce emergency room visits by ten percent by assigning a primary	DMAS formally define strategic goals for the SMA that is defined in measurable terms. Contract Performance Measures (SLAs) are used by contract administrators to measure the performance of contractors as stated in each contract. DMAS • develops a strategic plan • performs ongoing revisions • publishes an executive management report • distribute periodic dashboards/progress reports to executive team

PL Health Plan Administration		
Manage Performance Measures		
Item	**Details**	**DMAS Differences/Comments**
	care case manager. *Mechanism:* The SMA generates monthly report comparing emergency room usage by member for the period prior to and after Primary Care Case Managers (PCCM) assignment.	
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive request to revise or develop new performance measures and/or reporting. • Notification of a periodic review of measures and/or reporting is due. • Receive notification for executing a periodic monitoring activity. • Receive notice describing an incident requiring monitoring.	
Result	• Update to the criteria, mechanisms, and/or reports utilized to monitor performance measures. • Produce reporting related to the incident analysis or periodic monitoring results. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request or reach scheduled review time. 2. Review existing performance measures and reports.	Step 8: Contractors that do not meet baseline performance standards may be required to submit corrective action plan.

PL Health Plan Administration		
Manage Performance Measures		
Item	**Details**	**DMAS Differences/Comments**
	3. Revise, delete or add to existing measures and reports. 4. Produce updated definition of performance measures. 5. Monitor business activity against established performance measures. 6. Assess resulting information with business intelligence methods (i.e., historical, current and predictive views of business operations). 7. Produce reporting. 8. **END:** Disseminate information to designated members (e.g., individuals or business processes).	
Shared Data	Business Activity data store including performance information (e.g., CAPHS and HEDIS measures)	Performance measures are defined in the contract.
Predecessor	**NOTE:** Any MITA business process could be a predecessor to any performance monitoring activity depending on the performance measures. ***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Identify Utilization Anomalies***	

PL Health Plan Administration		
Manage Performance Measures		
Item	**Details**	**DMAS Differences/Comments**
	Manage Compliance Incident Information	
Successor	**Send Outbound Information** ***Manage Health Plan Information*** ***Formulate Budget*** ***Establish Compliance Incident*** ***Manage Data*** ***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Maintain State Plan***	
Constraints	The SMA will comply with federal and state regulations. Business intelligence tools have different abilities depending on the tool utilized and technical configuration.	
Failures	• Inability to access relevant information.	
Performance Measures	• Time to complete the process = within hours,____minutes • Accuracy with which State Medicaid Enterprise applies updates -100% • Consistency with which State Medicaid Enterprise applies updates- 100%	A performance measures varies per measure and contract. DMAS has taken steps to improve performance measure in past twelve months through training, front end reviews of RFPs, developed templates for SMART measures.

PL Health Plan Administration		
Manage Performance Measures		
Item	**Details**	**DMAS Differences/Comments**
	• Error rate = 0 % • Effectiveness of performance measures - • Ease of implementation of performance measures	Checks are in place at various intervals to ensure accuracy. SMART Additional steps are taken such as front end reviews of RFP's to ensure that measures are strategic, results oriented, and time bound.

3.9.2.2.2 As-Is Assessment

The overall rating for the Manage Performance Measures business process is '2'. DMAS has an established process for standardized dashboard reporting to the Secretary's Office on a periodic basis. However, some of the processes and tools in place are not used consistently on a timely basis.

Other items noted in the As-Is assessment were:

- DMAS/State Strategic Plan and Executive Progress Reports are located on the following public sites:
  - State site: http://vaperforms.virginia.gov/ with multiple links and info including national rankings http://vaperforms.virginia.gov/Trends/nationalRankings.php
  - Agency site within this: https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp_Agency&rdAgReset=True&Agency=602 (Note: currently reflects 2012-2014 information)
- Standardization/guidance/training for reporting, etc. can be found at the Department of Planning & Budget web site: http://dpb.virginia.gov/sp/sp.cfm
- The Governor requested all agencies to participate in "Enterprise Strategic Priorities" that reflects additional statewide efforts. The Executive Agreement is an agreement and partnership among the Governor, Cabinet Secretary and Agency Head in aligning the key agency goals with the 2014 Governor's Enterprise Strategic Priorities. The Executive Agreement is intended to foster effective and timely communication, mutual accountability, and positive and effective working relationships.

3.9.2.2.3 To-Be Assessment

DMAS intends to maintain Level '3' functionality for the Manage Performance Measures business process but look for opportunities to further improve the capabilities.

Specific changes identified include:

- Expanding the automation the Manage Performance Measures business process to the fullest extent possible in a cost-effective manner, including information collection
- Evaluating operational business processes against an established intrastate SLA and KPI and when DMAS does not meet a target, create and execute a corrective Plan of Action with Milestones
- Adopting any relevant industry standards and information exchange with intrastate agencies
- Identifying and tracking performance measures and using them to identify process improvements.

3.9.2.2.4 Scorecard

The following scorecard was compiled for Manage Performance Measures business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PL – Health Plan Administration Manage Performance Measures	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	3	3
Performance Measure		
Supporting Evidence Reference		

Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.9.3 Health Benefits Administration

As shown in Figure 3.9-1, the Health Benefits Administration business category is made up of following three business processes:

- Manage Health Benefit Information
- Manage Reference Information
- Manage Rate Setting

Details regarding the assessment of each Plan Administration business process follow.

3.9.3.1 Manage Health Benefit Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Health Benefit Information business process.

3.9.3.1.1 Business Process Model

The Manage Health Benefit Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PL Health Benefit Administration		
Manage Health Benefit Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Health Benefit Information*** business process includes the activities for development and implementation of health benefit packages to accommodate service	Policy defines and develops Health Benefit Information and operational areas implement, which could

PL Health Benefit Administration		
Manage Health Benefit Information		
Item	**Details**	**DMAS Differences/Comments**
	delivery to targeted member populations. The health benefit package accommodates information to support current and future health benefit packages for members eligible for programs administered by the State Medicaid Agency (SMA). The SMA determines benefit terms and limitations, and applicable periods for services defined within a health benefit package. Health benefit package administration involves the ability to determine, define and coordinate and modify the following parameters within the SMA, as the Medicaid Enterprise policies, funding and business decisions dictate: • Multiple health benefit package definitions targeted to specific populations. • Service categories to define available covered service. • Federal and state regulations define service limitations to restrict utilization. • Customization of edits and audits relative to SMA policy. • Utilization tracking of limited services at the member level. • Generation of state and federal reporting requirements.	include requests for system and/or data changes.
Trigger Event	State transition-based Trigger Events: • Receive information to load as initial records or updates to existing records from any Business Area. Interaction-based Trigger Events to include but not limited to: • Receive inquiry for health benefit information from enterprise business processes.	

PL Health Benefit Administration		
Manage Health Benefit Information		
Item	**Details**	**DMAS Differences/Comments**
	• Receive an inquiry from authorized external parties (e.g., a legislator requests outcome measures for a particular program). Environmental Trigger Events: • Periodic or near real-time transmission of program information to authorized external parties or systems, (e.g., Centers for Medicare & Medicaid Services (CMS) or Medicaid Statistical Information System (MSIS)).	
Result	All Business Areas load new or updated information and have access to the Health Benefit Information data store to use for analysis, reporting, and decision reporting including: • Response to inquiries from authorized requestors and/or applications. • Provision to all other Health Plan Management business processes with program information as needed (i.e., to develop benefit packages and drug formularies, set rates, analyze and project budgets, perform accounting functions, manage federal financial participation (FFP), measure quality, outcomes and performance, and develop policies and strategic initiatives, etc.). • Provision to all MITA business processes with program information needed (e.g., to manage communications, manage business relationships, perform outreach and education, and manage contracts). • Delivery of information to external parties or systems for reporting (e.g., CMS Medicaid Statistical Information System (MSIS) and public health for population health studies). • Delivery of modification to health benefits to Health Insurance Marketplace for	

PL Health Benefit Administration		
Manage Health Benefit Information		
Item	**Details**	**DMAS Differences/Comments**
	certification. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** The modification of health plan policy determines the health plan benefit packages that require definition or modifications to comply with the policy. 2. Create and modify health plan benefit packages that support definition of services available for various SMA programs. 3. Define the effective date and duration of the health plan benefit packages. 4. Define the health plan benefit package coverage narrative. 5. Define services specific to unique health plan benefit packages. 6. Specify limitations at both the service and monetary levels relative to health plan benefit packages and service categories. 7. Define any applicable member monetary constraints that include co-pay, co- insurance, deductible, and share of cost amounts, limits, and lifetime maximums. 8. **END:** Send health plan benefit services to Health Insurance Marketplace for certification.	DMAS does not send to Health Insurance Marketplace for certification. Once defined, appropriate

PL Health Benefit Administration		
Manage Health Benefit Information		
Item	**Details**	**DMAS Differences/Comments**
		operational areas implement.
Shared Data	Business Activity data store including performance information (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures) Plan data store including policy and health benefit information Health Benefit data store including benefit package and benefits information Provider data store including provider network and contract information Contractor data store including provider network and contract information Member data store including applicant or member demographics, enrollment, financial, social, functional and clinical information Claims data store including payment history	
Predecessor	***Develop Agency Goals and Objectives*** ***Maintain Program Policy*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Rate Setting*** ***Manage Reference Information***	
Successor		

PL Health Benefit Administration		
Manage Health Benefit Information		
Item	**Details**	**DMAS Differences/Comments**
	Manage Health Plan Information ***Manage Reference Information*** ***Manage Data***	
Constraints	Policies and procedures will differ by state, especially those relating to information standards, record keeping, and privacy.	
Failures	• Inability or failure to load initial records, properly analyze, update, or locate existing records in the Business Activity data store.	Programming errors can result in a Health Benefit being implemented incorrectly
Performance Measures	• Time to store information = within ___minutes • Time to access information = within minutes • Error rate =___% or less	To the extent that Benefit Information is stored as data in tables, updates (store) and access are handled through real-time or automated batch processes.

3.9.3.1.2 As-Is Assessment

The overall rating for the Manage Health Benefit Information business process is '2'. Health benefit information is stored in MMIS and other member related data stores. However, it is not easy to trace health information back to corresponding policy.

Other items noted in the As-Is assessment were:

- The result of Maintain Program Policy business process defines and develops Health Benefit Information and operational areas implement, which could include requests for system, and/or data changes.
- DMAS does not send modifications of health plan policy to the Health Insurance Marketplace for certification.

3.9.3.1.3 To-Be Assessment

DMAS intends to maintain Level '3' functionality for the Manage Health Benefit Information business process but look for opportunities to further improve the capabilities.

Specific changes identified include:

- Expanding the automation the Manage Health Benefit Information business process to the fullest extent possible in a cost-effective manner, including information collection
- Increasing flexibility within health benefit packages, enabling consumer driven health care with more choices among services and provider types
- Adopting any relevant industry standards and information exchange with intrastate agencies
- Sharing Health Benefit information with Health Insurance Marketplace (HIX)
- Identifying and tracking performance measures and using them to identify process improvements.

3.9.3.1.4 Scorecard

The following scorecard was compiled for Manage Health Benefit Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PL – Health Benefits Administration Manage Health Benefit Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	1	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		

Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.9.3.2 Manage Reference Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Reference Information business process.

3.9.3.2.1 Business Process Model

The Manage Reference Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PL Health Benefit Administration		
Manage Reference Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Reference Information*** business process is responsible for all operations aspects for the creation, modification, and deletions of reference code information. The ***Process Claim*** business process additions or adjustments trigger this business process. Additional triggers for ***Manage Reference Information*** business process include the addition of a new health plan or benefit, or the modification to an existing program due to the passage of new state or federal legislation, or budgetary modifications. The business process includes revising code information (e.g., Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), National Drug Code (NDC)), and/or revenue codes. Business process also adds rates associated with those codes and	Does not have anything to do with member or provider information. Highlighted portion is not affiliated with the process.

PL Health Benefit Administration		
Manage Reference Information		
Item	**Details**	**DMAS Differences/Comments**
	updates existing rates. The business process updates and adds information from the ***Manage Member Information*** and ***Manage Provider Information*** business processes as well as drug formulary, health plan and health benefit information. Designate Approved Services and Drug Formulary The Designate Approved Services and Drug Formulary activity is responsible for review of new and/or modified service codes (e.g., HCPCS, International Classification of Diseases (ICD) or NDC) for possible inclusion in various Medicaid Benefit programs. The State Medicaid Agency (SMA) may include or exclude certain services and drugs in each benefit package. Internal or external team(s) of medical, policy, and rates staff review service, supply, and drug codes to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that the SMA will meet. Review includes the identification of any modifications or additions needed for regulations, policies, and or Medicaid State Plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.	
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive new or modification of reference information from ***Process Claim*** business process. • Receive new or modification of health plan information from ***Manage Health Plan Information*** business process.	• DMAS receives drug file weekly from first data bank. • Highlighted trigger events are not applicable.

PL Health Benefit Administration		
Manage Reference Information		
Item	**Details**	**DMAS Differences/Comments**
	• Receive new or modification of health benefits information from ***Manage Health Benefit Information*** business process. Environment-based Trigger Events to include but not limited to: • Addition or modification to health plan or health benefit as directed by state or federal legislation or budgetary modifications. • Receive revised reference code set by industry standards organization. • Annual, bi-annual, quarterly or other review of newly established or modified service codes and National Drug Codes as published by maintainers of medical codes.	
Result	• Addition or modification of reference code set elements. • Alert sent to notify provider and contractor of reference code addition or modification. • Approved services and drug formularies established and defined. • The SMA approved or denied service codes and NDC codes for inclusion or exclusion in one or more Medicaid Health Plan. • Alert sent to notify impacted member of approved services and drug formulary. • Alert sent to ***Manage Rate Setting*** business process to establish rates for approved services and drug formulas. • Tracking information as needed for	Not applicable: • Alert sent to notify impacted member of approved services and drug formulary.

PL Health Benefit Administration		
Manage Reference Information		
Item	**Details**	**DMAS Differences/Comments**
	measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive addition or modification of reference information. 2. Review addition or modification to determine impact to coverage requirements based on current benefit programs. 3. Add or update codes or rates, including pre- and post-verification for accuracy. 4. Add or update member benefits, including pre- and post-verification for accuracy. 5. Add or update drug formulary information, including pre- and post-verification for accuracy. 6. Add or update program under which services are available. 7. **END:** Send alert to notify provider and contractor of reference code addition or modification. <u>Designate Approved Services and Drug Formulary</u> 1. **START:** Receive addition or modification of codes information. 2. Review new or modified coding to determine impact to coverage requirements based on current benefit programs. 3. Approve addition or elimination of services or NDC. 4. Determine coverage policies. 5. Review and identify modifications to Medicaid State Plan. 6. Review and identify modifications to regulations. 7. Recommend modifications to the State	#2 is not applicable #4 is not applicable #7 is not applicable

PL Health Benefit Administration		
Manage Reference Information		
Item	**Details**	**DMAS Differences/Comments**
	Medicaid Enterprise. 8. **END:** Send alert to notify provider, contractor, and impacted member of approved services and drug formulary.	
Shared Data	Reference data store including code set, drug formulary, and service code formulary information Member data store including health benefits information Provider data store including provider network information Contractor data store including provider network information Health Benefit data store including benefit and rate information	
Predecessor	**Receive Inbound Transaction** ***Manage Rate Setting*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Process Claim*** ***Process Encounter***	
Successor	***Process Claim*** ***Process Encounter*** ***Manage Rate Setting*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Manage Applicant and Member Communication***	

PL Health Benefit Administration		
Manage Reference Information		
Item	**Details**	**DMAS Differences/Comments**
	Manage Data	
Constraints	The SMA will maintain the Reference data store according to federal and state- specific policies and procedures, and comply with any code authority requirements. The SMA establishes service and drug formularies. Policies and procedures may differ from state to state.	
Failures	• The review does not take place prior to the effective date of the codes.	
Performance Measures	• Time to complete process: e.g., Real Time response = within 45 seconds, Batch Response = within __1_ days • Accuracy of decisions = __100__% • Consistency of decisions and disposition =__100__% • Error rate = _0_% or less	Ability to update the system, within 60 seconds.

3.9.3.2.2 As-Is Assessment

The overall rating for the Manage Reference Information business process is '2'. The process is well automated as DMAS receives file updates from outside entities and applies automated batch updates. There are also manual updates through real-time, on-line transactions.

One other item noted in the As-Is assessment was:

- DMAS follows the Manage Reference Information process, however the result does not impact the Manage Member Information and Manage Provider Information business processes.

3.9.3.2.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Manage Reference Information business process.

Specific changes identified include:

- Automatically verify the files updates with reduced manual interventions by incorporating automatic decision-making using standardized business rules definitions
- Improving timeliness via state and federal collaboration, use of reference information sharing, standards and regional information exchange hubs
- Improving efficiency and accuracy of manage reference information
- Identifying and tracking performance measures and using them to identify process improvements.

3.9.3.2.4 Scorecard

The following scorecard was compiled for Manage Reference Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PL – Health Benefits Administration Manage Performance Measures	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3

Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.9.3.3 Manage Rate Setting

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Rate Setting business process.

3.9.3.3.1 Business Process Model

The Manage Rate Setting business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PL Health Benefit Administration		
Manage Rate Setting		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Rate Setting*** business process responds to requests to add or modify rates for any service or product covered by the Medicaid Program.	Provider Reimbursement establishes provider rates for all services other than pharmacy (drugs) and new CPT procedure codes without an RVU. Provider Reimbursement also establishes capitation rates for all managed care products.
Trigger Event	Environment-based Trigger Events to include but not limited to: Receive official request for rate setting addition or modification. Periodic timetable is due for rate addition or modification. Receive the addition or modification of rate information.	Regulations trigger periodic rate updates for services The Appropriation Act triggers rate changes for services The agency has determined that it will update managed care rates annually

PL Health Benefit Administration		
Manage Rate Setting		
Item	**Details**	**DMAS Differences/Comments**
Result	• The State Medicaid Agency (SMA) defines new rate with effective date and date span. • The SMA rejects rate request. • Alert sent to notify provider and contractor of rate modification. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START**. Receive notification of request for addition or modification of rate. 2. Research and analyze rate, which may include request information to determine initial or updated rate. 3. Validate rate requested or establish rate. 4. Optional: Perform What-if scenarios analysis. 5. Create rate update or deny the request. 6. **END:** Send alert to notify provider and contractor of rate addition or modification.	Rate setting is typically initiated due to timetable or new process, like Duals (CCC) program; sometimes rates are negotiated for out of state providers. #4: This is performed at times but not typical Prog Ops – for drugs, follow the below process steps (excluding Point of sale drugs) such as vaccines, chemo. Everything but for step 4.
Shared Data	Business Activity data store including performance measures Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) information	DMAS maintains a rate web page. DMAS is beginning to use HEDIS as part of managed care rate setting; this is a 3 year process that is just being started.

PL Health Benefit Administration		
Manage Rate Setting		
Item	**Details**	**DMAS Differences/Comments**
	Plan data store including policy information Health Benefit data store including benefit package and benefit information Claims data store including payment information Provider data store including provider network and Contract information Contractor data store including provider network information	Rates are not based on provider performance. Claims base year information is reviewed Encounter data from MCOs are used for managed care rate setting Provider network information is not used in rate setting
Predecessor	***Manage Health Plan Information***	Also ***Manage Health Benefit Information*** Manage Cost Settlement can result in rate updates
Successor	***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Provider Communication*** ***Manage Contractor Communication*** ***Manage Reference Information***	Rate setting process may be used as input to future changes in Health Plan and/or Health Benefits. Manage Capitation Payment is also a Successor business process.
Constraints	The SMA will conform to mandates from the legislature or court. For a new service, procedure or product, information may not exist to assist in establishing a rate.	
Failures	• The SMA does not have enough information to validate rate or perform What-if scenario analysis delaying or interrupting the process.	Rates are established if needed by making and documenting assumptions.

PL Health Benefit Administration		
Manage Rate Setting		
Item	**Details**	**DMAS Differences/Comments**
	• Process includes possible denial of rate setting request.	Budget delays hold up the rate setting process.
Performance Measures	• Time to establish/update rate or reject rate request = __ hours or days • Accuracy: The process produces acceptable results __% of the time • Efficiency: Combination of staff plus automated processes results in utilization of __ FTEs per occurrence of this process	Rates are posted 30 days prior to effective date The time to establish/update a rate depends on the request (simple (hours) to complex (months)) Accuracy = 100% Efficiency depends on the request

3.9.3.3.2 As-Is Assessment

The overall rating for the Manage Rate Setting business process is '2'. DMAS is beginning to use HEDIS as part of rate setting; this is a three year process that is just being started.

Other items noted in the As-Is assessment were:

- The Manage Rate Setting business process is triggered by the Appropriation Act.
- Rate setting is typically initiated due to timetable or new process, like Duals (CCC) program; sometimes rates are negotiated for out-of-state providers.
- Manage Capitation Payment is also a Successor business process.

3.9.3.3.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Manage Rate Setting business process.

Specific changes identified include:

- Automating the Manage Rate Setting business process to the fullest extent possible in a cost-effective manner, including information collection and decision-making using standardized business rules
- Adopting any relevant industry standards and information exchange with intrastate agencies
- Identifying and tracking performance measures and using them to identify process

improvements.

3.9.3.3.4 Scorecard

The following scorecard was compiled for Manage Rate Setting business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PL – Health Benefits Administration Manage Rate Setting	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	3	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	3	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	3	3
Performance Measure		

Supporting Evidence Reference	

3.10 PROVIDER MANAGEMENT

OVERVIEW

The Provider Management business area is a collection of business processes involved in communications between the SMA and the prospective or enrolled provider and actions that the agency takes on behalf of the provider. Business processes focus on terminating providers, communications with providers, dealing with provider grievances and appeals issues, and performing outreach services to providers. The Provider Management business area is responsible for the provider data store.

The Provider Management business area and its supporting business capabilities and business processes are depicted below in Figure 3.10-1.

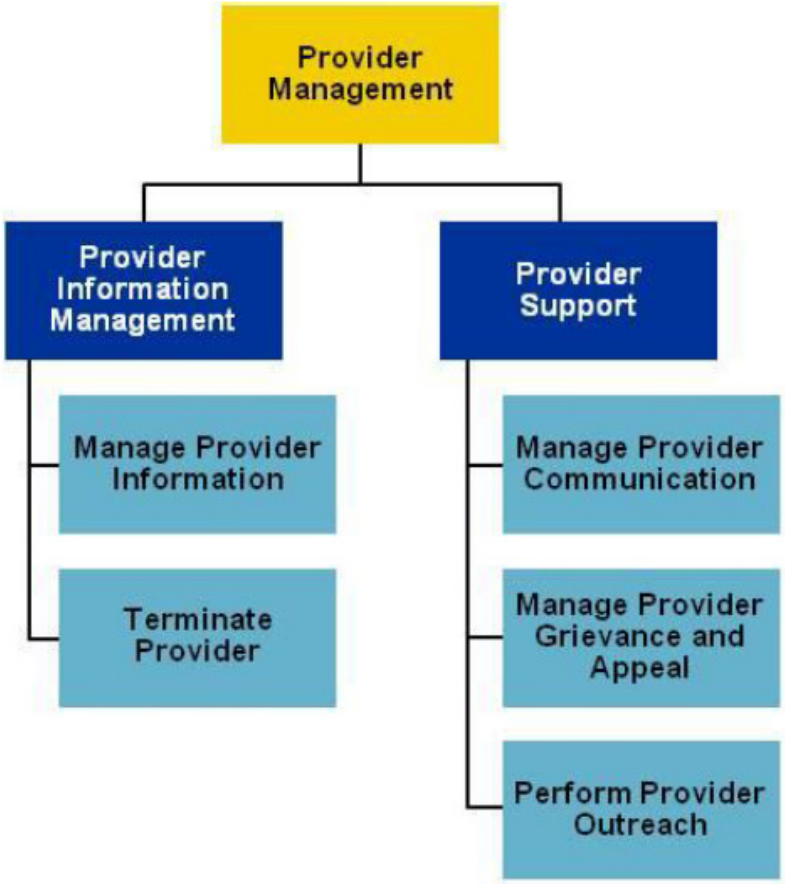


Figure 3.10-1

BUSINESS ARCHITECTURE PROFILE

The Provider Management Business Architecture Profile provides a summary and illustration of the As-Is and To-Be capability levels as a result of the SS-A. Each DMAS business process is profiled based on its scorecard.

Business Architecture Profile – Provider Management					
Business Process	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Manage Provider Information		As-Is	To-Be		
Terminate Provider		As-Is	To-Be		
Manage Provider Communication		As-Is	To-Be		
Manage Provider Grievance and Appeal		As-Is	To-Be		
Perform Provider Outreach		As-Is	To-Be		

3.10.1 Provider Information Management

As shown in Figure 3.10-1, the Provider Information Management business category is made up of 2 business processes:

- Manage Provider Information
- Terminate Provider

Details regarding the assessment of each Provider Information Management business process follow.

3.10.1.1 Manage Provider Information

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Provider Information business process.

3.10.1.1.1 Business Process Model

The Manage Provider Information business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PM Provider Information Management

Manage Provider Information		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Provider Information*** business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers and their interactions with the State Medicaid Agency (SMA). The Provider data store is the SMA Source of Record (SOR) for provider demographic, business, credentialing, enumeration, performance profiles, payment processing, and tax information. The data store includes contractual terms (e.g., the services the provider is to provide) related performance measures, and the reimbursement rates for those services. In addition, the Provider data store contains records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification, and all communications with or about the provider, including provider verification requests and responses, and interactions related to any grievance/appeal. The Provider data store may store records or pointers to records for services requested and services provided, performance, utilization, and program integrity reviews, and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member data store to add, delete, or modify information. The Provider data store validates information upload requests, applies instructions, and tracks activity. The Provider data store provides access to provider records to applications and staff via batch record transfers, responses to queries, and subscription services.	Some provider information is maintained outside of VAMMIS, such as by the ASOs (Behavioral Health and DentaQuest) and capitated vendors such as for managed care and transportation services. Some internal business units also maintain unique occurrences of provider information, such as Appeals. The ECM is used to maintain provider application information that is not stored on a database. Help Line uses Omnitrack to log complaints
Trigger Event	Environment-based Trigger Events to include but not limited to: • Receive request to create, inquire, delete, or modify provider information from authorized individuals via email, mail, facsimile, telephone or web.	This includes provider information received in batch files from ASOs and vendors .In some cases this

PM Provider Information Management		
Manage Provider Information		
Item	**Details**	**DMAS Differences/Comments**
	• Receive request to verify provider information from authorized external parties.	information is manually loaded.
Result	• The SMA creates, inquires on, modifies or deletes provider information. • Alert sent to notify Health Insurance Marketplace of provider network modification information. • Alert sent to notify insurance affordability program (i.e., Medicare, CHIP and Basic Health Program) of provider network modification. • Alert sent to ***Manage Provider Communication*** to notify provider of relevant modifications. • Tracking information as needed for measuring performance and business activity monitoring.	Health Insurance Marketplace is n/a We notify OIG of terminations, not others
Business Process Steps	1. **START:** Receive request from authorized individuals or agencies to create, inquire, delete or modify provider information. 2. Agency logs request for provider information. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 4. Validate the authorization by requestor to acquire provider information. 5. Find appropriate provider.	In some cases the 'log' will be paper

PM Provider Information Management		
Manage Provider Information		
Item	**Details**	**DMAS Differences/Comments**
	6. Create, inquire, delete or modify relevant provider information. 7. Send alert to notify Health Insurance Marketplace of provider network modification. 8. Send alert to notify insurance affordability program of provider network modification. 9. Send alert to ***Manage Provider Communication*** to notify provider of relevant modifications 10. **END:** The SMA creates, inquires on, deletes, or modifies provider information.	#7 is not done #8 is not done Relevant includes enrollment status changes Are processes validated or audited for ASOs? (Research for SS-A report, perhaps)
Shared Data	Provider data store including provider network, contract, demographics, application, eligibility, enrollment, grievance, appeals and communications information Financial data store including payment information Plan data store including policy information Health Benefit data store including benefit program and benefit information Claims data store including claim status and claims payment information Care Management data store including case management, health record, and clinical data information Business Activity data store including performance information	Grievances are stored in Omnitrack Health records are not maintained Interpreted as data to support performance measurements
Predecessor	**Receive Inbound Transaction** ***Determine Provider Eligibility***	

PM Provider Information Management		
Manage Provider Information		
Item	**Details**	**DMAS Differences/Comments**
	Enroll Provider ***Disenroll Provider*** ***Terminate Provider*** ***Perform Provider Outreach*** ***Manage Provider Communication*** ***Manage Provider Grievance and Appeal*** ***Establish Compliance Incident*** ***Determine Adverse Action Incident***	
Successor	**Send Outbound Transaction** ***Determine Provider Eligibility*** ***Enroll Provider*** ***Disenroll Provider*** ***Terminate Provider*** ***Perform Provider Outreach*** *Manage Provider Communication* **Manage Provider Grievance and Appeal** **Manage Provider Recoupment** **Manage Contractor Payment** **Manage Capitation Payment** **Establish Compliance Incident** **Manage Data**	Program Integrity may result in updates, such as setting a flag to suspend payments
Constraints	State-specific workflows determine which processes load and access the Provider data store and by which interactions and messages (e.g., query/response, batch uploads, publish and subscribe, etc.), the information content and how they will structure data store records, as well as determine how to validate the incoming information prior to updating the Provider data store. Archive information in accordance with state and federal record retention requirements.	Note that some processes are manual, such as related to paper storage
Failures	• Requestor has no authorization to the provider information.	

PM Provider Information Management		
Manage Provider Information		
Item	**Details**	**DMAS Differences/Comments**
	• Unable to find requested Provider. • Provider information is not available for inquiry.	Unable to find could be caused by erroneous indexing Provider information may not be available due to program or status Manual processes are prone to error, such as misinterpreting false-positive database checks
Performance Measures	• Time to complete process: e.g., Real Time response = within _____ seconds, Batch Response = within ___ days • Accuracy of decisions =_____ • Consistency of decisions and disposition =_____ • Error rate = ____% or less	Maintenance is 5 business days for batch and paper requests 100% accuracy 100% consistency 2% error rate

3.10.1.1.2 As-Is Assessment

The overall rating for the Manage Provider Information business process is '2.' DMAS maintains and stores the provider data that is necessary for claims processing and reporting in the MMIS database. The ECM report repository is also used to maintain provider application information that is not stored in the MMIS database. In some cases DMAS vendors and ASOs (e.g. Transportation, Dental, Behavioral Health, and Managed Care Plans) also maintain provider data outside of the MMIS provider database. Overall accuracy of provider data is considered to be very good.

Other items noted in the As-Is assessment were:

- Some internal business units also maintain unique occurrences of provider information, such as the Appeals Division.
- The DMAS Help Line uses Omnitrack to log provider requests and complaints; however some

requests are logged manually on paper.

- DMAS notifies the Office of Inspector General (OIG) of provider network modification however, Health Insurance Marketplace and the insurance affordability program are not notified.
- 50% of online transactions complete in less than or equal to 5 seconds, 80% of online transactions complete in less than or equal to 30 seconds and 99.9% of online transactions complete in less than or equal to 2 minutes

3.10.1.1.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Manage Provider Information business process.

Specific changes identified include:

- Automating the Manage Provider Information business process to the fullest extent possible, including storing the enhanced provider background and screening information as well as application fees and widespread information exchange
- Sharing the provider network with the state Health Insurance Marketplace
- Standardizing business rules definitions for consistent validation within the state
- Automating and standardizing business rules definitions for decision-making
- Identifying and tracking performance measures and using them to identify process improvements.

3.10.1.1.4 Scorecard

The following scorecard was compiled for the Manage Provider Information business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PM - Provider Information Management Manage Provider Information	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		

Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.10.1.2 Terminate Provider

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Terminate Provider business process.

3.10.1.2.1 Business Process Model

The Terminate Provider business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PM Provider Information Management		
Terminate Provider		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Terminate Provider*** business process is responsible for the termination of provider agreement to participate in the Medicaid Program. The basis for termination can be: • Centers for Medicare & Medicaid Services (CMS) and the State Medicaid Agency (SMA) terminate a provider agreement if an individual provider:	A provider can request to be terminated

PM Provider Information Management		
Terminate Provider		
Item	**Details**	**DMAS Differences/Comments**
	○ Is not in substantial compliance with the requirements of participation, regardless of whether immediate jeopardy is present; or ○ Provider does not meet the eligibility criteria for continuation of payment as set forth in 42 CFR 488.412(a)(1). • CMS and the state may terminate a facility's provider agreement if a facility: ○ Is not in substantial compliance with the requirements of participation, regardless of whether immediate jeopardy is present; or ○ Facility fails to submit an acceptable Corrective Action Plan (CAP) within the timeframe specified by CMS or the SMA. • CMS and the SMA terminate a facility's provider agreement if a facility: ○ Fails to relinquish control to the temporary manager, if CMS or the SMA imposes that remedy; or ○ Facility does not meet the eligibility criteria for continuation of payment as set forth in 42 CFR 488.412(a)(1). The effect of termination of the provider agreement ends: (1) payment to the facility, and (2) any alternative remedy.	DMAS does not request CAPs, but adheres to CMS actions. The BHSA ASO issues CAPs DMAS has not been involved in situations involving a temporary manager.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive alert from ***Determine Adverse Action Incident*** business process to cease activities with provider. Environment-based Trigger Events to include	OIG, OAG, Program Integrity, or Appeals

PM Provider Information Management		
Terminate Provider		
Item	**Details**	**DMAS Differences/Comments**
	but not limited to: • Receive request to terminate provider. • Receive notification of termination of provider from insurance affordability program.	Can be manual (retirement, death, sanctions) or automated (licensing) This is not applicable
Result	• Removal of provider or contractor from participation in Medicaid Program. • Alert sent to notify provider via ***Manage Provider Communication*** business process of termination proceedings. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of termination proceedings. • If applicable, alert sent to notify public via ***Perform Population and Member Outreach*** business process of termination proceedings. • Alert sent to notify business partners via ***Manage Business Relationship Communication*** business process of provider termination. • Alert sent to notify Health Insurance Marketplace of provider termination information. • Alert sent to notify insurance affordability program of provider termination information. • Tracking information as needed for measuring performance and business activity monitoring.	Providers of service are not contractors Notify MCOs and others of terminations This is not applicable This is not applicable
Business Process Steps	1. **START:** Receive request to terminate provider. 2. Review determination of noncompliance and investigation materials. 3. Send alert to notify provider via ***Manage Provider Communication*** business process of termination	

PM Provider Information Management		
Terminate Provider		
Item	**Details**	**DMAS Differences/Comments**
	proceedings. 4. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of termination proceedings. 5. If applicable, send alert to notify public via ***Perform Population and Member Outreach*** business process of termination proceedings. 6. Conduct communications and investigations within required timeframes. 7. If provider had implemented systems and processes to ensure that the likelihood of further violation is remote, and there is adequate evidence that the provider is in compliance with the requirements, the SMA rescinds the termination action and puts the provider back into compliance. 8. If provider has not implemented systems and processes to avoid further violations, terminate the provider. 9. Send alert to notify business partners via ***Manage Business Relationship Communication*** of provider termination. 10. Send alert to notify Health Insurance Marketplace of provider termination information. 11. Send alert to notify insurance affordability program of provider termination information. 12. **END:** Remove provider or contractor from participation in Medicaid Program.	This is not applicable This is not applicable

PM Provider Information Management		
Terminate Provider		
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Provider data store including provider network and contract information Business Activity data store including performance information Compliance Management data store including compliance incident information Insurance Affordability Program data store including eligibility and enrollment information	 This is not applicable
Predecessor	**Determine Adverse Action Incident**	Includes both manual requests and automated processes, like licensure
Successor	**Manage Provider Communication** **Manage Contractor Communication** **Perform Population and Member Outreach** **Manage Business Relationship Communication**	Providers of service are not contractors Notify MCOs and others of terminations
Constraints	Before terminating a provider agreement, CMS and the SMA will notify the facility and the public: (1) At least two (2) calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and (2) At least 15 calendar days before the effective date of termination for a facility with non-immediate jeopardy deficiencies that constitute noncompliance.	DMAS does not notify the public, but affected members can be notified, like nursing home residents (1) 2 days notice not enforced; notification (a letter) is generated in the nightly batch process (2) 90-60-30 day notice when license or revalidation is due (to expire); BHSA ASO provides notification via CAPs.
Failures	• Unable to find requested Provider.	N/A for DMAS - Once a provider is

PM Provider Information Management		
Terminate Provider		
Item	**Details**	**DMAS Differences/Comments**
	• Provider information is not available for inquiry.	identified for termination, there is no current way the process can fail.
Performance Measures	• Time to complete termination process = within __ days • Consistency of decisions and disposition = ____% • Error rate = __% or less	10 days 100% consistency 0% error rate

3.10.1.2.2 As-Is Assessment

The overall rating for the Terminate Provider business process is '2.' The termination of a provider is often the result of a finding from OIG, OAG, Program Integrity, or the Appeals Division. In addition, a provider can request to be terminated. The termination process can be manual as is the case when a provider retires or dies, or when a provider is sanctioned. Termination of a provider due to a licensing issue is automated.

Other items noted in the As-Is assessment were:

- DMAS does not notify the Health Insurance Marketplace or the insurance affordability program when a provider is terminated.
- DMAS does not share eligibility and enrollment information data with the Insurance Affordability Program data store.
- DMAS does not notify the public when a provider is terminated, but affected members may be notified, e.g. nursing home residents.
- The termination process is completed within 10 days with a few exceptions such as termination to protect the health and welfare of members, loss of license, or incarceration.

3.10.1.2.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Terminate Provider business process.

Specific changes identified include:

- Automating the Terminate Provider business process to the fullest extent possible
- Sharing provider termination information with Health Insurance Marketplace (HIX)
- Collaborating with other intrastate agencies and entities to adopt national standards, and regional information exchange hubs

- Improving timeliness via state and federal collaboration, use of information sharing standards,
- Automating and standardizing business rules definitions for decision-making
- Identifying and tracking performance measures and using them to identify process improvements.

3.10.1.2.4 Scorecard

The following scorecard was compiled for the Terminate Provider business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PM - Provider Information Management Terminate Provider	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3

Performance Measure	
Supporting Evidence Reference	

3.10.2. Provider Support

As shown in Figure 3.10-1, the Provider Support business category is made up of 3 business processes:

- Manage Provider Communication
- Manage Provider Grievance and Appeal
- Perform Provider Outreach

Details regarding the assessment of each Provider Support business process follow.

3.10.2.1 Manage Provider Communication

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Provider Communication business process.

3.10.2.1.1 Business Process Model

The Manage Provider Communication business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PM Provider Support		
Manage Provider Communication		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Provider Communication*** business process receives requests for information, provides publications, and assistance from prospective and current providers' communications (e.g., inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements). The State Medicaid Agency (SMA) may communicate information using a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages. **NOTE:** ***Manage Provider Communication*** business process handles inquiry from prospective and current providers by providing assistance and responses to *individual entities* (i.e., bi-directional communication). Also included are scheduled communications such as program	A provider 'grievance' is considered an inquiry and handled as part of this process. DMAS does not initiate communication using mobile devices

PM Provider Support		
Manage Provider Communication		
Item	**Details**	**DMAS Differences/Comments**
	memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The ***Perform Provider Outreach*** business process targets both prospective and current provider *populations* for distribution of information about programs, policies, and health care issues.	
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive requests from other business processes to develop and produce communications for providers such as notifications from ***Enroll Provider*** business process. • Receive inquiries originating from customer help desk through ***Manage Provider Information*** business process. Environment-based Trigger Events to include but not limited to: • Receive inquiry from current or prospective provider. • Receive request to send information packages such as provider enrollment applications and/or billing instructions. • Receive request for assistance, such as a request for training or modify in provider information. • Periodic timetable (e.g. hours, monthly, and quarterly) is due to send information. For example, SMA sends communications within 24 hours of new provider enrollment or periodic publications such as newsletters.	
Result	• Current or prospective provider receives appropriate assistance, communications, appointment, and/or information packages.	

PM Provider Support		
Manage Provider Communication		
Item	**Details**	**DMAS Differences/Comments**
	• Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request for communication. 2. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and requestor has completed all required fields. 3. Validate that the provided information is authentic. 4. Agency logs request for communication. 5. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web, or EDI. 6. Determine performance measures. 7. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 8. Review and approve communication. 9. Generate communication in agreed upon format. 10. Agency logs communication message. 11. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate).	Mobile devices are not used to provide communication All provider communications are in English and they are not customized in any way for specific groups or individuals
Shared Data	Provider data store including provider network, contract, and grievance information	

PM Provider Support		
Manage Provider Communication		
Item	**Details**	**DMAS Differences/Comments**
	Plan data store including policy information Health Benefit data store including benefit package and benefit information Ancillary Communication Tracking Systems: Customer Relationship Management (CRM), Help Desk Log, Protected Health Information (PHI) disclosure log, etc.	Omnitrack tracks communication relative to provider inquiries and complaints
Predecessor	**Receive Inbound Transaction** *Determine Provider Eligibility* *Enroll Provider* **Disenroll Provider** **Terminate Provider** **Manage Provider Grievance and Appeal** **Maintain State Plan** **Manage Health Plan Information** **Manage Health Benefit Information**	
Successor	**Send Outbound Transaction** **Manage Provider Information** **Manage Performance Measures**	
Constraints	Communications requested will vary by state, depending on programs supported and type of provider requesting information. Provider may have communication barriers such as lack of internet or phone access. Provider is unable to access required or requested information.	
Failures	• SMA is unable to provide linguistically, culturally, or	Linguistic, cultural, and competency

PM Provider Support		
Manage Provider Communication		
Item	**Details**	**DMAS Differences/Comments**
	competency appropriate information. • Delivery failures due to erroneous contact information or lack of contact information.	appropriateness is not addressed by DMAS, but is not considered a failure.
Performance Measures	• Time to complete response: By phone minutes; by email __ hours; by mail ___ days • Accuracy of communications = __% • Communications successfully delivered = %	Communication (mail) is generated within 24 hours of initiating transaction 30 day response to written inquiries Standards are defined for answering phone calls: <5% abandon rate; 90% of calls answered <= 120 secs Accuracy = 100% Successfully delivered • To known address = 100% • No metrics for returned mail

3.10.2.1.2 As-Is Assessment

The overall rating for the Manage Provider Communication business process is '2.' The business process used at DMAS is very similar to the MITA business process with only a few minor exceptions. However, based on the provider demographics in Virginia, DMAS sends all provider communications in English and does not vary its communications to account for cultural or language differences.

Other items noted in the As-Is assessment were:

- Provider grievances are considered to be an inquiry and are handled as part of this process.
- DMAS uses Omnitrack to log provider inquiries and complaints.
- DMAS conducts a monthly provider workgroup meeting to discuss upcoming policy changes,

system issues, and answer provider questions.

3.10.2.1.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality for the Manage ProviderCcommunication business process.

Specific changes identified include:

- Automating the Manage Provider Communication business process to the fullest extent possible, including by email, Automatic Voice Response, telephone, facsmilie, web portal, or Electronic Data Interchange (EDI)
- Enhancing portal functionality to accommodate the needs of persons with disabilities including those who use assistive technology
- Using cost-effective electronic functionality that makes provisions for functionally, linguistically, culturally, and competency appropriate communications
- Improving timeliness via state and federal collaboration, use of information sharing standards, and regional information exchange hubs
- Responding to common inquiries in real-time
- Identifying and tracking performance measures and using them to identify process improvements.

3.10.2.1.4 Scorecard

The following scorecard was compiled for the Manage Provider Communication business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PM - Provider Information Management Manage Provider Communication	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3

Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

3.10.2.2. Manage Provider Grievance and Appeal

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Manage Provider Grievance and Appeal business process.

3.10.2.2.1 Business Process Model

The Manage Provider Grievance and Appeal business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PM Provider Support		
Manage Provider Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Manage Provider Grievance and Appeal*** business process handles provider* appeals of adverse decisions or communications of a grievance. The ***Manage Provider Communication*** business process initiates a grievance or appeal from a provider. The State Medicaid Agency (SMA) logs and tracks the grievance or appeal, triages it, and sends it to appropriate reviewers. Staff researches or requests additional information. The SMA may schedule a hearing, conduct actions in accordance with legal requirements, and make a	DMAS considers a 'grievance' as an inquiry that is handled as part of ***Manage Provider Communications*** and addressed in accordance with that process. There is no specific '***Manage Provider Grievance***' process.

PM Provider Support		
Manage Provider Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
	ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the provider's information. SMA formally notifies provider of the decision. This business process supports the ***Manage Performance Measures*** business process by providing information about the types of grievances and appeals it handles, grievance and appeals issues, parties that file or are the target of the grievances and appeals, and the dispositions. The SMA uses information to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. Based on the appeal business process, if a provider wins an appeal that affects or clarifies a Medicaid State Plan, health plan, or health benefit, this process sends that information to ***Maintain State Plan, Manage Health Plan Information*** or ***Manage Health Benefit Information*** business processes to modify the relevant policy or procedure. Disposition could result in legislative change requirements that the SMA will communicate to lawmakers. **NOTE:** States may define grievance and appeal differently, depending on state laws. States may involve multiple agencies in the ***Manage Provider Grievance and Appeal*** business process. *This business process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when SMA denies an application for enrollment.	MCOs and ASOs have their own internal grievance and appeal process prior to a DMAS appeal.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive grievance or appeal of adverse decision alert from ***Manage Provider Information***.	The adverse decision alert can come from a variety of processes or entities, including claims adjudication, service authorization, audits, and MCOs

PM Provider Support		
Manage Provider Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
		or other entities. Provider requests the appeal.
Result	• Alert sent to notify provider of final disposition of grievance or appeal. • If applicable, alert sent to ***Establish Compliance Incident*** business process for further investigation. • If applicable, alert sent to ***Maintain State Plan*** business process to modify the relevant policy or procedure. • If applicable, alert sent to ***Manage Health Plan Information*** business process to modify the relevant policy or procedure. • If applicable, alert sent to ***Manage Health Benefit Information*** business process to modify the relevant policy or procedure. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive grievance or appeal. 2. Agency logs grievance or appeal. 3. Validate information submitted is correct and as complete as possible. Information complies with syntax criteria and submitter has completed all required fields. 4. Validate that the provided information is authentic. 5. If appropriate, request additional documentation. 6. Determine status as initial, second, or	There is no expedited provider

PM Provider Support		
Manage Provider Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
	expedited or other status as designated by the state. 7. Triage to appropriate personnel for review. 8. Perform research and analysis. 9. If appropriate, schedule hearing within required time. 10. If appropriate, conduct hearing within required time. 11. Determine disposition. 12. If applicable, send alert to ***Establish Compliance Incident*** business process for further investigation. 13. If applicable, alert sent to ***Maintain State Plan*** business process to modify the relevant policy or procedure. 14. If applicable, alert sent to ***Manage Health Plan Information*** business process to modify the relevant policy or procedure. 15. If applicable, alert sent to ***Manage Health Benefit Information*** business process to modify the relevant policy or procedure. 16. **END:** Send alert to notify provider of disposition determination. **NOTE:** Some of the above steps may be iterative and a grievance or appeals case may take many months to finalize.	appeal. Regarding the "**NOTE**" - The processing of the provider appeal is in accordance with a strict statutory and regulatory timeline. Neither the Informal appeal process nor the formal administrative hearing may exceed 180 days.
Shared Data	Provider data store including eligibility, enrollment and provider network information Claims data store including claims and premium Information Grievance and Appeal data store including case history and Recovery Audit Contractor (RAC)	Also Service Authorization information

PM Provider Support		
Manage Provider Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
	adverse determination information Adverse Action data store including case history information	
Predecessor	**Manage Provider Information**	The adverse decision alert can come from a variety of processes or entities, including claims adjudication, service authorization, audits, and MCOs or other entities. Provider requests the appeal.
Successor	**Manage Provider Communication** **Maintain State Plan** **Manage Health Plan Information** **Manage Health Benefit Information** **Manage Performance Measures** **Establish Compliance Incident**	
Constraints	States may have different requirements for evidence and the process for conducting the grievance and appeals cases. They may have different rules for assigning outcome status and state specific consequences. The State Medicaid Agency will conform to state and federal regulations.	
Failures	• Grievance and Appeal supporting documentation is incomplete. • SMA cannot schedule or conduct hearing in the required period. • Final disposition was a result of summary judgment due to lack of timeliness within the process. • Provider withdraws grievance or appeal.	
Performance	• Time to complete process: normal	

PM Provider Support		
Manage Provider Grievance and Appeal		
Item	**Details**	**DMAS Differences/Comments**
Measures	grievance/appeal = __ days; second appeal = days; expedited appeal = ___ hours • Accuracy of decisions =___% • Consistency of decisions and disposition =___% • Error rate = __% or less	Normal maximum of 180 days for normal and second appeal; no expedited appeals Accuracy = 100% Consistency = 100% Error Rate = 0%

3.10.2.2.2 As-Is Assessment

The overall rating for the Manage Provider Grievance and Appeal business process is '2.' Processes are modeled on the federal APA and adhere to the Code of Virginia regulations, so industry and nationally recognized standards are followed. Accuracy of the processes and results are very high. Databases are now used that have automated functions for generating numerous reports and some routine form letters, notifications and templates.

Other items noted in the As-Is assessment were:

- The duration of process conforms to the regulation (180 calendar days)
- The use of the database improves timeliness and productivity
- Use of automation improves access and accuracy; information and process accuracy are 100%
- The functional capabilities of Level 3 are met, but processes do not fully comply with the MITA Framework
- While the processes are improved with the use of APEX and ECM, contractors and user groups are generally not satisfied with the length of time required.

3.10.2.2.3 To-Be Assessment

DMAS intends to achieve Level '3' functionality with regard to the Manage Provider Grievance and Appeal business process.

Specific changes identified include:

- Automating the Manage Provider Grievance and Appeal business process to include electronic capture of information where allowed by law
- Adopting industry and nationally recognized standards within the intrastate increasing coordination and reuse of standardized Grievance and Appeal business services
- Automating decision-making business rules

- Collecting information on the types of grievances and appeals and using it to improve programs reducing the issues that give rise to appeals
- Identifying and tracking performance measures and using them to identify process improvements.

3.10.2.2.4 Scorecard

The following scorecard was compiled for the Manage Provider Grievance and Appeal business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PM - Provider Support ***Manage Provider Grievance and Appeal***	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	2	3
Performance Measure		
Supporting Evidence Reference		
Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	2	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		

Supporting Evidence Reference	

3.10.2.3 Perform Provider Outreach

The following sections provide the business process model, a summary of the As-Is and To-Be assessments, and the Business Architecture scorecard for the Perform Provider Outreach business process.

3.10.2.3.1 Business Process Model

The Perform Provider Outreach business process model (BPM) was reviewed with business owners as part of the SS-A and annotated to identify DMAS differences and comments. The updated BPM appears below.

PM Provider Support		
Perform Provider Outreach		
Item	**Details**	**DMAS Differences/Comments**
Description	The ***Perform Provider Outreach*** business process originates internally within the State Medicaid Agency (SMA) in response to multiple activities (e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, modifications in the Medicaid Program policies and procedures). SMA may develop prospective Provider outreach information, also referred to as Provider Recruiting information, for targeted providers identified by analyzing program information (for example, not enough dentists to serve a population, new immigrants need language-compatible providers). Enrolled Provider outreach information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives. The State Medicaid Agency develops outreach information for target populations identified by analyzing member information. The State Medicaid Agency may communicate information in a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). The State Medicaid Agency produces, distributes, tracks and archives all contractor outreach communications according to state rules. The ***Manage Performance Measures*** business process defines benchmarks and measures	DMAS does not engage in provider recruiting. DMAS does not use mobile devices.

PM Provider Support		
Perform Provider Outreach		
Item	**Details**	**DMAS Differences/Comments**
	outreach efficacy. **NOTE:** The ***Perform Provider Outreach*** business process targets both prospective and current provider *populations* for distribution of information about programs, policies, and health issues. ***Manage Provider Communication*** business process handles inquiry from applicants, prospective and current providers by providing assistance and responses to *individuals* (i.e., bi-directional communication).	
Trigger Event	State transition Trigger Events: • Alert received from ***Manage Health Plan Information*** business process of addition or modification. • Alert received from ***Manage Health Benefit Information*** business process of addition or modification. Environment-based Trigger Events to include but not limited to: • Executive Management decision to: o Fill gaps in health care service and administrative coverage. o Solicit updated/new administrative and technical functions. o Introduce new programs requiring new types of health or administrative service. o Change existing policies and procedures. o Identify critical need for a specific target population. o Identify new populations in need of service (e.g., new immigrant communities).	Bullet 1: NA for Fee for Service; ASOs address Bullet 2: NA

PM Provider Support		
Perform Provider Outreach		
Item	**Details**	**DMAS Differences/Comments**
Result	• Agency produces outreach communications (e.g., mailing brochures, web pages, email, kiosk, and radio, billboard, and TV advertisements) and distributes to targeted providers. Agency may also conduct face-to-face meetings. • Tracking information as needed for measuring performance and business activity monitoring.	
Business Process Steps	1. **START:** Receive request for outreach materials or communication. 2. Target population is identified and defined by analyzing information, performance measures, feedback from community, and policy directives. 3. Approve, deny, or modify decisions to develop outreach communications. 4. Determine content and method of communication (e.g., email, mail, publication, mobile device, facsimile, telephone, web or EDI. 5. Determine performance measures. 6. Prepare content that is linguistically, culturally, and competency appropriate for the communication in agreed upon format. 7. Review and approve communication. 8. Generate communication in agreed upon format. 9. Agency logs communication message. 10. **END:** Evaluate the efficacy of the communication (e.g., customer satisfaction, first time resolution rate)	All provider outreach content is in English

PM Provider Support		
Perform Provider Outreach		
Item	**Details**	**DMAS Differences/Comments**
Shared Data	Provider data store including provider network, application and enrollment information Plan data store including policy information Health Benefits data store including benefit package and benefit information Performance Measures data store including agency's objectives Care Management data store including population health and treatment plan information Business activity data store including performance information Compliance Management data store including compliance incident information	Claims data results may be used to call attention to adjudication errors and how to resolve
Predecessor	***Manage Performance Measures*** ***Identify Utilization Anomalies*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information***	
Successor	**Send Outbound Transaction** ***Manage Provider Communication***	
Constraints	Communications and information packages will address the needs of the targeted population. Materials will be linguistically and culturally appropriate, legally compliant, appropriate to the targeted group, and meet financial guidelines (re: cost to produce and distribute). Other constraints	English only

PM Provider Support		
Perform Provider Outreach		
Item	**Details**	**DMAS Differences/Comments**
	may be agency priority, availability of resources, and accuracy of contractor contact information. Provider may have communication barriers such as lack of Internet or phone access. Provider is unable to access needed or requested information.	
Failures	• Unable to identify target population based on desired criteria. • Management denies permission for outreach activity. • Cancel health plan or health benefit. • Delivery failures due to erroneous contact information.	
Performance Measures	• Time to complete process of developing outreach materials = __days • Accuracy of outreach materials = __% • Successful delivery rate to targeted individuals = __% • Effectiveness of the communication – Outreach results in achieving specified goals (e.g., recruitment of new providers from targeted population)	30 day notice to policy changes, otherwise 'ad hoc' per initiative Training statistics are maintained, but there are no defined SLAs

3.10.2.3.2 As-Is Assessment

The overall rating for the Perform Provider Outreach business process is '2' however a few Level 1 capabilities were noted. DMAS uses a combination of manual and automated processes to perform provider outreach. State specific standards are applied to this process however the process is considered to be informal and inconsistent. Timeliness of the process varies depending on the type of outreach. For example, DMAS strictly enforces its standard that requires a Medicaid Memo to be sent to providers at minimum 30 days prior to implementation of a policy change in the MMIS. Other types of provider outreach tend to be handled on an 'ad hoc' basis per initiative.

Other items noted in the As-Is assessment were:

- DMAS does not engage in provider recruitment.
- The Behavioral Health vendor performs outreach to providers to attempt to fill gaps in service coverage.
  Training statistics are maintained, but there are no defined Service Level Agreements (SLAs)
- DMAS periodically surveys its providers to determine satisfaction levels (currently less than 90%).
- Outreach materials to providers are not tailored to be linguistically and culturally appropriate. Based on provider demographics in Virginia, all outreach materials are produced in English.

3.10.2.3.3 To-Be Assessment

DMAS intends to achieve an overall Level '3' for the Perform Provider Outreach business process.

Specific changes identified include:

- Automating outreach functions to the fullest extent possible
- Enhancing portal to include usability features or functions that accommodate the needs of persons with disabilities, including those who use assistive technology
- Using electronic communications that make provision of functionally, linguistically, culturally, and competency appropriate outreach
- Improving timeliness via state and federal collaboration, use of information sharing standards, and regional information exchange hubs
- Releasing alerts and information immediately
- Identifying and tracking performance measures and using them to identify process improvements.

3.10.2.3.4 Scorecard

The following scorecard was compiled for the Perform Provider Outreach business process as a result of the As-Is and To-Be assessments.

Business Architecture Scorecard		
PM - Provider Support Perform Provider Outreach	***As-Is Level of Business Capability***	***To-Be Level of Business Capability***
Overall Assessment Level	2	3
Timeliness of Process	1	2
Performance Measure		
Supporting Evidence Reference		

Data Access and Accuracy	2	3
Performance Measure		
Supporting Evidence Reference		
Cost-Effectiveness	1	3
Performance Measure		
Supporting Evidence Reference		
Effort to Perform; Efficiency	2	3
Performance Measure		
Supporting Evidence Reference		
Accuracy of Process Results	2	3
Performance Measure		
Supporting Evidence Reference		
Utility or Value to Stakeholder	2	3
Performance Measure		
Supporting Evidence Reference		

4.0 INFORMATION ARCHITECTURE ASSESSMENT

The Information Architecture was assessed using the Information Capability Matrix (ICM). The ICM defines the information capabilities used in a business process and informs the identification of technical capabilities. The ICM includes four (4) primary components:

- Data Management Strategy (DMS)
- Conceptual Data Model (CDM)
- Logical Data Model (LDM)
- Data Standards.

The relationship of the Information Architecture capability components is depicted below in Figure 4.0-1.

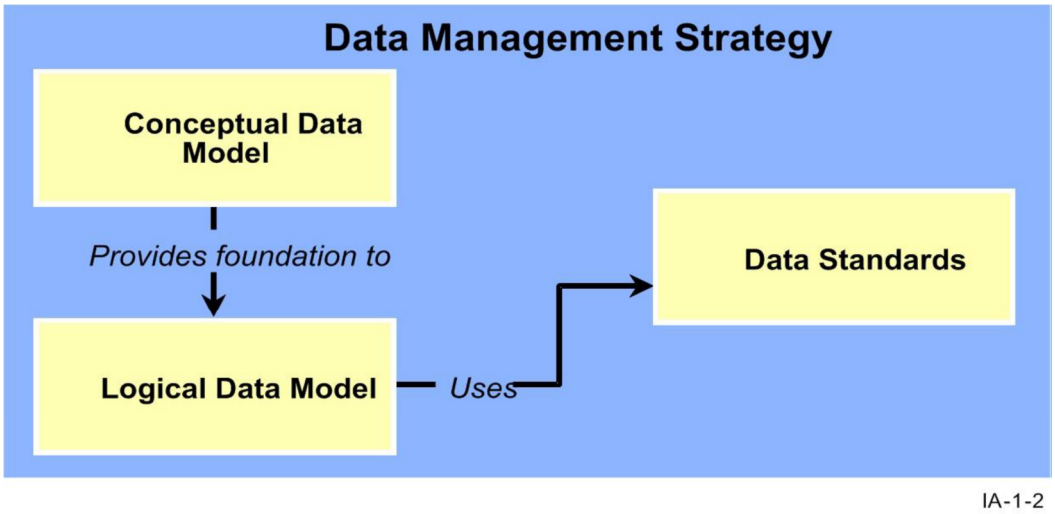


Figure 4.0-1 Information Architecture Components

DMAS created an Office of Data Analytics in 2014. This office is responsible for developing the overall Data Management Strategy for the Agency. Because the Agency is so early in the definition of our data strategy, all business areas are operating at a low level regarding information capabilities, and there is very little uniqueness about how the business areas currently approach the components defined in the ICM and our objectives for the future. It was therefore determined that reporting each business area separately would be essentially duplicating the same information, so the Information Architecture assessment is documented for the entire Agency and a single scorecard has been prepared.

4.1 INFORMATION ARCHITECTURE PROFILE

At the Agency level, our As-Is Information Architecture is assessed at Level 1, and our To-Be objective is to achieve Level 3.

Capability	Information Architecture Profile				
	Level 1	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Data Management	As-Is		To-Be		
Conceptual Data Model	As-Is		To-Be		
Logical Data Model	As-Is		To-Be		
Data Standards		As-Is	To-Be		

4.2 INFORMATION ARCHITECTURE ASSESSMENT

4.2.1 As-Is Assessment

The overall Information Architecture capability of the DMAS organization is assessed at Level 1. The agency relies upon electronic transactions with limited manually intensive components. Electronic data interchange (EDI) is used when trading data outside of the agency. EDI industry standards are followed as the agency supports the ANSI ASC X12 and NCPDP transaction sets. However, DMAS currently does not have a defined data governance process although one is anticipated to be adopted in 2015. Both conceptual and logical data modeling is not currently a requirement respective to database administration which results in the lineage of data often being unknown to the data and business analysts.

4.2.1.1 Data Management Strategy

Similar to other states, DMAS-owned data, both generated from system applications and integrated from other sources, has traditionally been managed with an orientation of meeting needs specific to the business process for which the data was generated. This has resulted in a siloed mentality where data tends to be seen as an asset to be created and leveraged by those who own it rather than anyone with a business need within or outside the agency. A lack of a data governance program, standards for data architecture and enterprise data modeling result in an assessment at Level 1 in most areas of data management strategy. An exception to this assessment is with EDI trading partners outside of the agency.

4.2.1.1.1 Governance

The term data governance, in itself, implies an enterprise wide attitude towards data and its management. Although business areas within DMAS may apply some standardization among themselves regarding data definitions, those standards cannot be considered implemented through a data governance structure unless it has involved all relevant parties across the enterprise and been executed through a formalized data governance process. DMAS assesses itself as being at Level 1 in this area as a data governance program does not currently exist for the agency.

With the establishment of the Office of Data Analytics in the beginning of 2014, the organization has demonstrated an investment in enterprise-wide data management. One of the immediate charges by leadership to this division has been the establishment of a DMAS data governance program. Throughout the final quarter of 2014, this office has led a team of business and data analysts from across the organization in the effort of drafting a data governance charter which would establish, at minimum, the following for the organization:

- Internal policy and procedures for data governance
- Formal appointment and "job descriptions" for data stewards and data owners
- Oversight and policy for data exchanges
- A requirement that data management processes align with Commonwealth data standards in support of the objective to limit intrastate redundancy.

4.2.1.1.2 Common Data Architecture

The organization assesses itself as being at Level 1 in regards to common data architecture. Although some standardization and efficiency are achieved for the agency by many of the business processes involved one software application (MMIS), this is not a comprehensive substitute for a common data architecture which requires that data be documented and managed according to organizational standards. As with data governance, the concept of internal policy and procedures for data documentation and metadata management themselves imply an enterprise-wide approach to metadata management. Without a metadata repository managed at an enterprise level, any metadata documentation by an individual business area cannot be considered universally accessible, documented or applied across the organization.

4.2.1.1.3 Enterprise Modeling

DMAS does not rely upon enterprise modeling to abstractly represent the structures, processes and data sources available to and leveraged by the organization. A fundamental requirement for having enterprise modeling would be a high level understanding of all the data sources accessible to the organization. A lack of an enterprise understanding of all data sources in the organization is a symptom of the siloed mentality previously described. Additional, conceptual data models and logical data models would need to be documented by the organization as part of enterprise modeling. Given the state of the current environment regarding data modeling, the agency assesses itself at Level 1.

4.2.1.1.4 Data Sharing Architectures

DMAS uses EDI industry standard X12 transaction sets for sharing healthcare-related data with Medicaid providers, managed care organizations and financial institutions. However, two major barriers exist to DMAS considering itself fully aligned with these structural standards. DMAS has elected to adopt a high level of customization in its electronic data interchanges which dilutes standardization determined by the Accredited Standards Committee (ASC) X12N – Insurance Subcommittee. Additionally, there are claims accepted by DMAS which do not follow EDI industry standards. Given these challenges to fully adoption of data sharing architectures, DMAS assesses itself at Level 1 in this area.

4.2.1.2 Conceptual Data Modeling (CDM)

Data modeling is not an activity that has been adopted enterprise-wide within the agency – putting the agency at Level 1 in this area. Adoption of data modeling is complicated by the fact that data is generated from a variety of sources which may not necessarily be managed by a data custodian in DMAS' Information Management (IM). Without clarity about who the data custodian, data owner and data stewards are for each data source, it is difficult to know who to bring together to develop a conceptual data model. Additionally in the current environment, data analysts tend to rely upon either their own knowledge about a business process or by interviewing business analysts on an ad hoc basis which results in analyses which are inefficiency formed outside of a standardized process. Some external data exchanges are handled by individual units through a business associates agreement (BAA) negotiated between them and a third party. Without data governance or another centralized method for documenting such BAAs, abstractly representing data passing to and from external entities as well as any associated business process can be challenging.

4.2.1.3 Logical Data Modeling (LDM)

Conceptual modeling would likely be a first step towards engaging in logical data modeling for the agency. The agency assesses itself to be at Level 1 for logical data modeling in alignment with where it is in conceptual data modeling. The same barriers which exist for creating a CDM are also present when considering the development of LDMs. Without logical data modeling, the gap between the data analysts and the subject matter experts (SMEs) can be crippling with neither parties being able to translate what the other one needs. Consequently, data analysts either have to become SMEs themselves or they have to ask the SMEs to become experts on the data by specifying data elements for each report, instead of having them focus only on articulating the business need. Either option dilutes the organization's ability to have each party focus on their area of expertise as well as resulting in a great deal of misunderstanding between the two groups.

4.2.1.4 Data Standards

Leveraging data standards is a strength for the organization as the environment has naturally shifted towards industry structure and vocabulary data standards in the MMIS. Homegrown data elements have largely been phased out in favor of HIPAA compliant vocabulary standards. Specifically, the agency relies upon the following vocabulary standards:

- Code on Dental Procedures and Nomenclature (CDT)
- Current Procedural Terminology, Fourth Edition (CPT-4)
- Diagnosis Related Group (DRG)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases (ICD-9-CM and ICD-10)
- National Drug Codes (NDC).

It should be noted that although the organization does rely upon these vocabulary standards, the MMIS does not always apply all standardized codes received in data exchanges but sometimes only those which are relevant to fee-for-service transactions. Consequently if an external vendor transmits data which includes codes relevant to their businesses practices but not Medicaid fee-for-service, some data may be missing in the final record for the organization respective to the original transaction. Additionally, the current infrastructure does not favor accepting data beyond those transactions required to operate existing processes.

Structural data standards tend to be applied in routine data exchanges – particularly with third parties as part of contractual requirements. As previously mentioned, data exchanges to DMAS from other trading partners are highly customized and in certain instances do not follow EDI format. Intrastate data exchanges tend not to follow structural standards and any adherence to vocabulary standards exist as a result of data exchanges with the original trading partner.

Given that the organization has made some effort to follow industry and vocabulary standards, the agency assesses itself at Level 2 through its continual effort to close the gap between internally developed data standards and industry expectations.

4.2.2 To-Be Assessment

At Level 2, information capability is described as being "…a mix of manually intensive components and electronic transactions or automated functionality internal to the SMA." A Level 3 environment requires that DMAS have data governance, a CDM, a LDM, enterprise modeling, industry standards, nationally recognized standards for intrastate exchanges of information, and partner agencies within Virginia. With the formation of the Office of Data Analytics, the agency has begun taking the steps necessary to achieve Level 2. It is our plan that within the next 5 years we will be able to build upon our Level 2 capabilities and achieve Level 3 by defining and supporting intrastate information exchanges in accordance with MITA definitions and as part of the Medicaid Enterprise System (MES) transition. This evolution will be accomplished by implementing several data management practices, including:

- A data governance program
- An enterprise CDM and LDM
- A well-managed data warehouse complete with dimensional data modeling
- Data ownership and stewardship
- An exhaustive metadata repository and adoption of industry standards.

Achieving these goals in a progressive manner over the next 2-5 years will be pivotal for the agency and will significantly evolve our data management maturity. We also recognize that achieving Level 3 will require the cooperation and commitment of other State agencies, which must be mandated and supported at the State level.

4.2.2.1 Data Management Strategy

The goal for DMAS regarding data management strategy is to first fully implement all components of Level 2, and then continue to progress to Level 3, including:

- **Data governance**: Currently, DMAS has not adopted an enterprise level data governance program. Data ownership, data quality monitoring, and industry standardization are not required of data assets. The application of data management principles when overseeing data is optional and inconsistently applied. The agency intends to transition to an environment where policies and procedures for data governance are adopted including formal recognition of data ownership and stewardship by the appropriate individuals, and ultimately to limit the redundancy within the intrastate.

- **Common data standards**: The agency intends to use data governance as the launching point for developing policies and procedures for data definitions, data standardization, data quality, data processing and metadata management, leading to the adoption of an intrastate metadata repository.
- **Enterprise data warehouse**: DMAS intends to create a single centralized enterprise warehouse to manage formal reporting and analysis of data. This will provide a platform to profile data, incorporate data policies uniformly across disparate data sources, define exhaustive data needs for the organization, and create a standardized reporting structure.
- **Enterprise analysis and reporting platform**: As a part of standardization and transparency initiative, DMAS also intends to create a single platform for reporting and analyzing data. This will streamline and secure dissemination of reporting in a secure environment.
- **Enterprise modeling**: Enterprise modeling is another goal of the agency as part of its data maturity evolution. This should include both entity relationship diagrams for OLTP and multi-dimensional for OLAP and an enterprise wide metadata repository for data assets.
- **Data sharing standards**: Data sharing presently between DMAS and other trading partners tends to be facilitated at an individual level, lack universal adherence to data sharing rules, and be inconsistent regarding the application of structural data standards. It is the goal of the agency to standardize data sharing, require industry standard data sharing formats (e.g. NIEM, HIPAA, HL7, etc.) within the Medicaid enterprise and ultimately with intrastate partners, and, whenever possible, reduce data redundancy by making data easily accessible to appropriate stakeholders as opposed to an environment where individuals independently develop their own data sharing solutions.

4.2.2.2 Conceptual Data Modeling (CDM)

DMAS intends to transition to Level 3 in conceptual data modeling. The first step is evolving towards Level 2 in conceptual data modeling by gaining an understanding of the current and the future data requirements of the organization. In order to better understand the existing issues and requirements, DMAS will conduct a full data inventory and appropriately assign data ownership responsibilities. Once that is achieved, the organization will define the business objects and ascertain the relationship that clearly defines the business needs. The knowledge of the data stewards will help the designers ratify some of the relationships. The DMAS CDM will be developed with the objective of supporting intrastate data exchanges and leveraged to initiate adoption of the exchanges with other State agencies to reach Level 3.

4.2.2.3 Logical Data Modeling (LDM)

After conceptual data modeling, the agency intends to develop both logical and physical data models. Once an understanding of business objects are reviewed and understood by designers, the agency intends to document the attributes, referential integrity and structural integrity of the objects. Data definitions and standards defined by governance will be incorporated in this stage. As with the CDM, the LDMs will be developed in a manner that will ultimately support intrastate exchanges.

4.2.2.4 Data Standards

The agency intends to initially maintain Level 2 maturity regarding data standardization but eventually achieve Level 3. Industry structural and vocabulary standards will be applied wherever possible to data

and data exchanges. DMAS will continue to comply with HIPAA requirements. We will also look at using data standards that are consistent with T-MSIS and other reporting requirements to avoid the need for crosswalks. We expect to continue to evolve our data standards so that DMAS is in a position to engage in intrastate exchanges that meet the MITA Framework as other State agencies are prepared to participate.

4.4 INFORMATION ARCHITECTURE SCORECARD

The following scorecard was compiled for the Information Architecture as a result of the As-Is and To-Be assessments.

Information Architecture Scorecard		
Information Area	***As-Is Level of Component Capability***	***To-Be Level of Component Capability***
Overall Assessment Level	1	3
Data Management	1	3
Supporting Evidence Reference		
Conceptual Data Model	1	3
Supporting Evidence Reference		
Logical Data Model	1	3
Supporting Evidence Reference		
Data Standards	2	3
Supporting Evidence Reference		

5.0 TECHNICAL ARCHITECTURE ASSESSMENT

The Technical Architecture (TA) is a consolidation of principles, models, and guidelines that form a template for states to use in developing their own operating model to guide the evolution of their foundation for execution. By using best practices, industry standards, and technological advancements, the processes and planning guidelines that build the MITA framework provide a cohesive method for meeting State Medicaid objectives. The TA should align with the MITA seven standards and conditions.

5.0.1 Technical Architecture Components: The Technical Architecture (TA) components form an integrated architecture that provides standardization, data sharing, and interoperability.

- Technical Management Strategy
- Business Services
- Technical Services
- Application Architecture (AA)
- Technical Standards
- Technical Capability Matrix (TCM)

5.0.1.1 Technical Management Strategy–Provides the background and process for expanding Medicaid systems to incorporate modern-day technologies into the Medicaid Enterprise. The involvement of sound software-design-architecture practices and technology advances such as Cloud Computing will provide the foundation for enhanced capabilities.

5.0.1.2 Business Services–This component implements a business capability for a business process. It is a basic element in Cloud Computing and Service Adoption architecture. The goal of the TA is to specify business services that allow interoperable Medicaid business processes.

5.0.1.3 Technical Services–This component consists of a detailed set of technical functions that collectively define the MITA technology infrastructure. Within given Technical Service Classifications (TSC) and corresponding Technical Service Areas (TSA), the TA defines the technical software services. Section 5.0.2, below, describes the Technical Service areas.

5.0.1.4 Application Architecture–Provides the information necessary to develop enterprise applications using business and technical services.

5.0.1.5 Technical Standards–This component consists of the Technical Reference Model (TRM) and a Standards Profile. The TRM is a list of technical services, either aggregated or broken down into levels that specify the standards. The Standards Profile includes current, future, and emerging industry standards.

5.0.1.6 Technical Capability Matrix–Defines a set of high-level technical functions to enable the MITA business capabilities, and support the success of the Medicaid mission and goals, while meeting the MITA goals and objectives. The TCM supplements the Business Capability Matrix (BCM), and the Information Capability Matrix (ICM) in defining a benchmark for States to transform themselves in accordance with MITA principles. Each technical capability consists of one or more technical services.

Figure 5.0-1 depicts the MITA Service-Oriented Architecture.

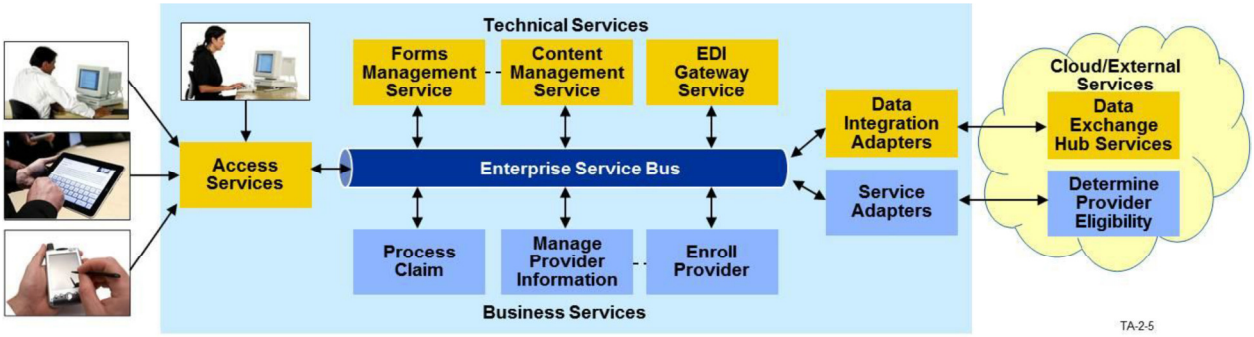


Figure 5.0-1 The MITA SOA

5.0.2 Technical Service Areas: A technical service is a piece of software that executes a generic IT capability. It has a defined interface for its invocation, performs a defined function that corresponds to the capability, and returns defined results. The MITA Technical Services Framework consists of three (3) TSAs:

5.0.2.1 Access and Delivery–Encompasses design drivers and enablers such as web browser connectivity, language support, Customer Relationship Management (CRM), and forms and reports services. The access and delivery functions have a direct impact on the state staff, the public, providers, and all other stakeholders. The span of coverage of the services offered will tend to change over time as the demands and technology needs of the end user evolve.

5.0.2.2 Intermediary and Interface–Contains drivers and enablers, such as process orchestration, workflow, and relationship management functionality. The Enterprise Service Bus (ESB) offerings handle the intermediary services (sometimes referred to as middleware). The interface services tie to connectivity offerings of the nearby Medicaid Enterprise entities and other external organizations that require a connection.

5.0.2.3 Integration and Utility–Includes design drivers and enablers such as solution stacks, database access layer services, scalability, application versioning, and verification-type utility services. These core service components will likely be a combination of the unique services and a set of reusable services across the Medicaid Enterprise.

Figure 5.0.2-1 shows the conceptual depiction for the MITA TSAs.

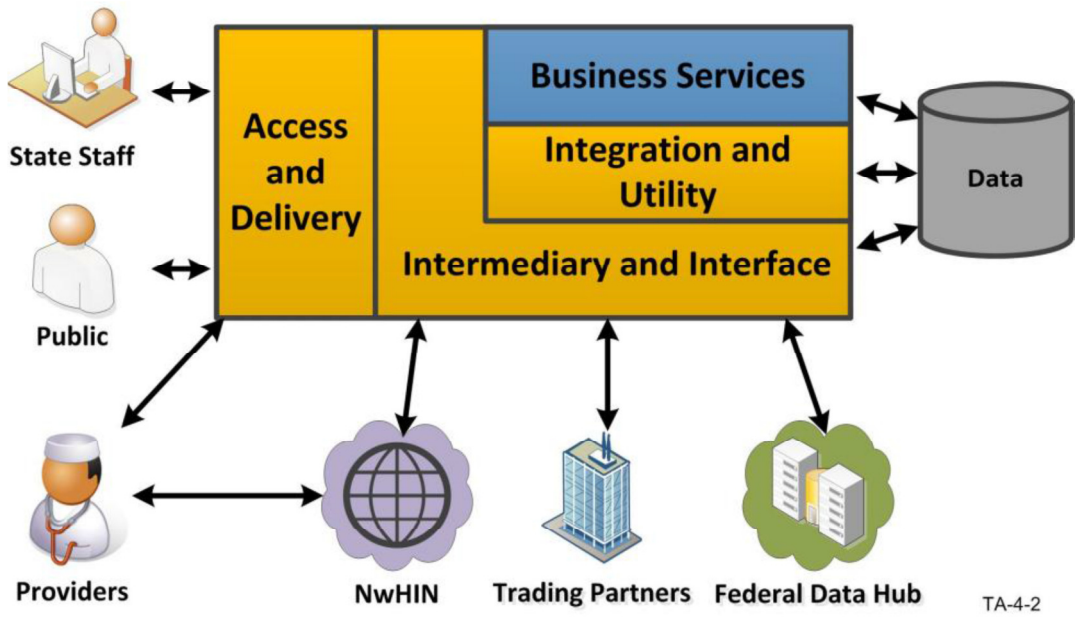


Figure 5.0.2-1 TSAs Conceptual Diagram

The layering of the types of services requires a combination of services for an end user to retrieve data. The Interface and Integration TSA handles orchestration of events.

5.0.3 Architecture Dependencies: The interrelated Business Architecture (BA), Information Architecture (IA), and TA function together to provide the Medicaid Enterprise System. The BA describes the business processes along with data input, data output, and required shared data. The IA provides the bridge between the business view of operations and the technical view of the data. The TA describes the technology enablers associated with different levels of maturity. It is important to understand that there is no one-to-one match between business, information, and technical capabilities.

5.1 TECHNICAL ARCHITECTURE PROFILE:

The Medicaid TA Profile presents the current As-Is operational baseline ratings and the targeted To-Be capability goals for each of the business areas identified in the Business Architecture Profile. Each business area was assessed, using the TCM, by Technical Service Area and Technical Service Classification. The TA Profile depicts the As-Is and To-Be technical architecture ratings across all business areas.

Technical Architecture Profile					
Business Area	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Access and Delivery		**As-Is**	**To-Be**		
Intermediary and Interface	**As-Is**		**To-Be**		
Integration and Utility		**As-Is**	**To-Be**		

5.2 TECHNICAL ARCHITECTURE ASSESSMENT

Technical principles shape MITA's definition and the SMA maturity of the State Medicaid Enterprise. The MITA TA foundation originates from the following technical principles:

- Business driven–MITA uses technology when it supports a business goal or objective; technology should not exist for technology's sake alone. Technical solutions will map to specific business needs.
- Implementation neutral–States are responsible for selecting their own technology (e.g., Oracle J2EE, Microsoft.NET) to accomplish alignment with the MITA objectives.
- Platform independent–Stakeholders will develop reusable and platform-independent application software.
- Adaptable, extensible, and scalable–States will use SOA-based applications so that they can develop them in a modular fashion to accommodate future expanding business requirements.
- Open technology and standards based–Stakeholders will leverage the advantages of standardization (e.g., data sharing and interoperability).
- Integrated Security and privacy–States will maintain security and privacy of information throughout the MITA Framework.
- Interoperability standards–Stakeholders will establish and follow the MITA SOA design principles to insure seamless functionality between services and other entities.
- Quality data–States will design systems to establish the ability to provide the most current data so that they can make business decisions in a timely and accurate manner.
- Current and proven technology–Stakeholders will select up-to-date established technology to support current business needs.

5.2.1 As-Is Assessment:

5.2.1.1 Access and Delivery

5.2.1.1.1 Client Support. While stakeholders generally have client support available through the portal, **i**n Business Relationship Management, the stakeholders do not have this functionality available through the portal. In Provider Management, the Commonwealth of Virginia's Medicaid Web Portal facilitates providers' and their user organizations' access to secured provider services such as Provider Enrollment forms etc.

5.2.1.1.2 Business Intelligence: Business intelligence information is available for specific business functions using SAS. The agency limits access to a small group of stakeholders.

5.2.1.1.3 Forms and Reporting: Throughout most of the enterprise, no established workflow exists; however, under Financial Management, Operations Management, Performance Management, and Provider Management, the agency and stakeholders conduct data entry using electronic forms, and the agency produces automated and ad hoc reports to support business needs. Reports are stored in an Enterprise Content Management (ECM) system for easy retrieval and archiving.

5.2.1.1.4 Performance Measurement: Generally, metrics are reported using ad hoc reporting methods. There is some use of predefined reporting methods that are based on contractual service level agreements (SLAs).

5.2.1.1.5 Security and Privacy: The agency provides a secure role-based access to staff and providers to the online portals. The agency restricts access to data based on defined access roles using security software and in some cases, program logic. The agency provides a secure managed file transfer solution for secure transfer of data.

5.2.1.2 Intermediary and Interface

5.2.1.2.1 Business Process Management: Business processes consist primarily of manual, sometimes paper-based, activity to accomplish tasks. The agency is not using MITA initiative for business, architecture, and data.

5.2.1.2.2 Relationship Management: The agency applies a mix of HIPAA and state-specific standards for service support.

5.2.1.2.3 Data Connectivity: The agency does mostly automated information exchange of between multiple organizations; there are a few areas where the manual information exchange in non-standard formats occurs.

5.2.1.2.4 Service-Oriented Architecture: The agency uses a mix of manual and electronic transactions to conduct business activity. The agency uses some isolated web services.

5.2.1.2.5 System Extensibility: The agency uses a mix of manual and electronic transactions to conduct business activity. Provider Management also uses some isolated web services.

5.2.1.3 Integration and Utility

5.2.1.3.1 Configuration Management: The agency uses a mixture of manual and automated configuration management methodologies. The automated configuration management processes use CM software tools.

5.2.1.3.2 Data Access and Management: The agency uses standard EDI format and non-standard formats for most of the electronic information exchange via a secure hub. In some areas, there is manual information exchange between multiple organizations. Information requests are sent via e-mail for data processing.

5.2.1.3.3 Decision Management: The agency uses a mixture of table-driven and hard-coded business rules in the core application code in support of enforcing some business decisions. Most of the business process happens in batch environment. The business rules are stored externally in document repository which is used as the basis for creating specifications for development.

5.2.1.3.4 Logging: The agency has access to the users' activity history and other management functions, including log-on approvals/disapprovals and log search and playback.

5.2.1.3.5 Utility: The business processes consist mostly of automated activities involving integration through a database. The agency incorporates industry standards in requirements, development, and testing phases of project. The agency uses web services in isolated areas.

5.2.2 To-Be Assessment

5.2.2.1 Access and Delivery

5.2.2.1.1 Client Support: The Commonwealth of Virginia's Medicaid Web Portal plans to facilitate the beneficiaries and providers with access to a secure portal for services like Provider Enrollment, Claims Status Inquiry, Member Eligibility and Service Limits, Claims Submission, etc.

5.2.2.1.2 Business Intelligence: The agency is moving towards a data-warehouse solution to develop a robust enterprise analytics platform with defined data governance policies, enforcement, and a publishing platform to enable all the stakeholders with easy access to data for analysis.

5.2.2.1.3 Forms and Reporting: The agency plans to adopt real time submission of claims, clinical, and other reporting information.

5.2.2.1.4 Performance Measurement: The agency plans to report performance measures and metrics using predefined metrics and reporting methods.

5.2.2.1.5 Security and Privacy: The agency plans to provide member and provider access to service through a secure portal. The agency will leverage the commonwealth authentication service for user authentication and access to data elements based on defined access roles. The agency will provide staff with Single Sign-On functionality to a majority of the applications in the State Medicaid Enterprise.

5.2.2.2 Intermediary and Interface

5.2.2.2.1 Business Process Management: The agency plans to automate most of the manual business workflows using business process management standards.

5.2.2.2.2 Relationship Management: The agency plans to apply a mix of MITA, industry, and national standards for service support.

5.2.2.2.3 Data Connectivity: The agency plans to conduct the electronic information exchange with other agencies via a secure information hub. The agency will perform information monitoring and

enforce rules to trigger alerts to detect exceptions. The agency will use industry standard formats and canonical formats for data exchange.

5.2.2.2.4: Service-Oriented Architecture: The agency plans to leverage the existing investment in the enterprise service bus for orchestration, integration, and guaranteed message exchange. The agency will use SOA and System Development Life Cycle methodologies and ensures seamless coordination and integration with intrastate agencies and entities.

5.2.2.2.5 System Extensibility: The agency plans to use RESTful and/or SOAP based web services for integration with other agencies and external vendors using canonical interfaces.

5.2.2.3 Integration and Utility

5.2.2.3.1 Configuration Management: The agency plans to strive towards automated configuration management methodology.

5.2.2.3.2 Data Access and Management: The agency plans to use standard formats for data exchange. The agency will adopt information archiving solutions to meet data-retention policies and compliance guidelines.

5.2.2.3.3 Decision Management: The agency plans to leverage its investment in the rules engine tool to implement business processes like adjudication.

5.2.2.3.4 Logging: The agency plans to leverage the commonwealth authentication service for user authentication and role based authorization to system resources.

5.2.2.3 5 Utility: The agency plans to provide services to the stakeholder community to perform most of the business functions using self-service. The agency incorporates industry standards in requirements, development, and testing phases of project. The agency will use web services in most of the business areas.

5.2.3 TECHNICAL ARCHITECTURE SCORECARD

Technical Architecture Scorecard		
Technical Service Area	**As-Is Level of Technical Service Capability**	**To-Be Level of Technical Service Capability**
Overall Level	2	3
Access and Delivery		
Client Support	2	3
Business Intelligence	2	3

Forms and Reporting	2	4
Performance Measurement	2	3
Security and Privacy	2	3
Intermediary and Interface		
Business Process Management	1	3
Relationship Management	2	3
Data Connectivity	2	3
Service-Oriented Architecture	1	3
System Extensibility	1	3
Integration and Utility		
Configuration Management	1	3
Data Access and Management	2	3
Decision Management	2	3
Logging	2	3
Utility	2	3

6.0 SEVEN STANDARDS AND CONDITIONS

Under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act, CMS has issued new standards and conditions that it expects States to adhere to in order for Medicaid technology investments (including eligibility systems, as well as traditional claims processing systems) to be eligible for enhanced federal matched funds. The intent is to foster better collaboration with States, reduce unnecessary paperwork, and focus attention on the key elements of success for modern systems development and deployment.

The 7Ss&Cs consist of the following:

- **Modularity Standard –** Uses a modular, flexible approach to systems development, including the use of open interfaces and exposed Application Programming Interfaces (API); the separation of business rules from core programming; and the availability of business rules in both human and machine-readable formats. The States commit to formal system development methodology and open, reusable system architecture.
- **MITA Condition** –States align to and advance increasingly in MITA maturity for business, architecture, and data.
- **Industry Standards Condition** – Ensures alignment with, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal Civil Rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act.
- **Leverage Condition** – State solutions should promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States.
- **Business Results Condition** – Systems should support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public.
- **Reporting Condition** – Solutions should produce transaction data, reports, and performance information that contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.
- **Interoperability Condition** – Systems must ensure seamless coordination and integration with the Exchanges (whether run by the state or federal government), and allow interoperability with Health Information Exchange (HIE), public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.

DMAS has completed its review of the MITA 7Ss&Cs, and the results of that review are provided below.

6.1 SEVEN STANDARDS AND CONDITIONS PROFILE

The Seven Standards and Conditions profile for each of the architectures is provided below.

6.1.1 Business Architecture

A Business Architecture 7Ss&Cs review was conducted for each of the ten business areas. The combined results of those reviews are reflected in the following Profile.

Seven Standards and Conditions Profile					
Business Architecture	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Modularity Standard	As-Is	To-Be			
MITA Condition		As-Is	To-Be		
Industry Standards Condition	As-Is	To-Be			
Leverage Condition	As-Is	To-Be			
Business Results Condition	As-Is	To-Be			
Reporting Condition		As-Is	To-Be		
Interoperability Condition	As-Is	To-Be			

6.1.2 Information Architecture

Seven Standards and Conditions Profile					
Information Architecture	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***
Modularity Standard	As-Is	To-Be			
MITA Condition		As-Is	To-Be		
Industry Standards Condition		As-Is To-Be			
Leverage Condition	As-Is	To-Be			
Business Results Condition	As-Is	To-Be			
Reporting Condition	As-Is	To-Be			
Interoperability Condition	As-Is	To-Be			

6.1.3 Technical Architecture

Seven Standards and Conditions Profile					
Technical Architecture	***Level 1***	***Level 2***	***Level 3***	***Level 4***	***Level 5***

Modularity Standard	As-Is		To-Be		
MITA Condition	As-Is		To-Be		
Industry Standards Condition		As-Is	To-Be		
Leverage Condition	As-Is		To-Be		
Business Results Condition	As-Is		To-Be		
Reporting Condition	As-Is		To-Be		
Interoperability Condition	As-Is		To-Be		

6.2 SEVEN STANDARDS AND CONDITIONS ASSESSMENT

6.2.1 Business Architecture

6.2.1.1 Seven Standards and Conditions Assessment

The overall As-Is 7Ss&Cs rating for the Business Architecture is Level 1. Many of the individual As-Is ratings for the business areas had Level 2, including the Eligibility and Enrollment Management, Financial Management, and Provider Management; however, these did not raise the overall As-Is level to a Level 2. The To-Be objective for most business areas is Level 2 with plans to raise current As-Is Level 2 items to Level 3.

Modularity Standard

DMAS generally has not espoused breakdown of business functions and as a result, there is minimal modularity throughout the DMAS MMIS enterprise. The business areas that are rated as Level 2 for this standard are Eligibility and Enrollment Management, Financial Management, and Provider Management.

Many of the Eligibility and Enrollment Management business areas employ BPM methodologies and maintain standardized business rules definitions. The Business Relationship Management business area includes Business Associate Agreements (BAAs), Trading Partner Agreements (TPAs), and Inter-Agency SLAs used by DMAS with standard business rules and processes. Many of the Care Management business processes are contracted out for DMAS related business. Some contractors employ BPM methodologies to accomplish the associated DMAS business processes. Many of the Financial Management business areas have identified primary business operations and maintain standardized business rules definitions through use of state and federal standards and rules. Finally, many of the Provider Management business processes employ BPM methodologies and maintain standardized business rules definitions used for related functions.

MITA Condition

Based on DMAS's SS-A completed for the use in this document's generation, all DMAS business areas have been rated as Level 2.

Industry Standards Condition

DMAS applies both HIPAA and state-specific data standards in the current environment, and it intends to continue with this practice in the coming years. Where possible, DMAS will also apply industry or national standards in business process modeling and maintenance. All DMAS business areas use SDLC methodologies for all phases of project implementations. The business areas that are rated as Level 2 for this standard are Eligibility and Enrollment Management and Provider Management.

The Eligibility and Enrollment Management and Provider Management business processes use work-flow and business process engineering based on state and federal standards. The Financial Management business processes for DMAS uses State systems and COTS products that ensure General Accounting Principles standards, as well as Federal fiscal standards, are applied. The Operations Management business processes use national standards for HIPAA transactions, NCCI processing, and EFT payments.

Leverage Condition

For the SMA DMAS, very little collaboration, if any at all, occurs with other agencies to leverage or reuse business processes. There are no business areas that exceeded a Level 1.

Business Results Condition

DMAS requires SLAs to be addressed in all contracts issued; however none are generally associated to measuring the effectiveness of the business processes implemented as most are based on metrics associated to operational statistics measurement. There are none used by DMAS internally for the measurement of business processes either, so it is difficult to enforce on others what DMAS does not do. Communication with providers and the public are very effective and are continuously improving based on MMIS enhancements. This standard has the 2nd most Level 2 ratings for the 10 business areas included in MITA. The business areas that are rated as Level 2 for this standard are Business Relationship Management, Eligibility and Enrollment Management, Financial Management, Operations Management and Provider Management.

For the Eligibility and Enrollment Management business area, the new VaCMS processes and interfaces for members and the new provider enrollment processes provide greater usage of automated business processes with related work-flow technology. For the Financial Management business areas, DMAS communicates effectively and efficiently with providers for payments, recoupments, and with members for HIPP payments and processes. Account access for providers is automated via web-portal services. For the Operations Management and Performance Management business areas, DMAS currently has web portals and other sources for information to providers for claims status reporting for paid and denied claims. All processing has associated SLAs that are used for timely processing. For the Provider Management business areas, new provider enrollment and maintenance applications implemented in

the MMIS and maintained by the DMAS FA provides greater usage of automated business processes with related work-flow technology.

Reporting Condition

DMAS's business processes for this standard comprise the highest rating for the As-Is and could easily be at Level 2 as 8 of the 10 business areas were rated at this level. DMAS has a lot of processes solutions in place to produce transaction data, reports, and performance information that contribute to program evaluation and continuous improvement in business operations. The reporting solutions are included in DMAS's many audit contracts in place that are specifically associated with reviewing, identifying, and providing information associated with claims adjudication errors that results in continuous improvements, the DMAS Fiscal Agent (FA) with their QA process to evaluate and improve the business operations they are contracted to do, and in-house SAS and Executive Support Systems (ESS) data warehouse. The business areas that are rated as Level 2 for this standard are Business Relationship Management, Care Management, Eligibility and Enrollment Management, Financial Management, Operations Management, Performance Management, Plan Management, and Provider Management.

For the Plan Management business areas, DMAS has implemented a new organization, the Office of Data Analytics with their main directive to be focused on reporting and analysis to support DMAS's Division Directors need for review and improvements to current and new business processes and operations.

Interoperability Condition

DMAS has one business process that is integrated with a state all-payer claims exchange, however there were no business processes that currently coordinated or integrated any federal or national HIE as part of interoperability with other agencies. No business area was rated higher than Level 1 for this standard.

6.2.1.2 Business Architecture 7Ss&Cs Scorecards

A Business Architecture 7Ss&Cs review was conducted for each of the ten business areas and the results of those reviews are reflected in the following scorecards.

6.2.1.2.1 Business Relationship Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Business Relationship Management		
Modularity Standard	1	2
MITA Condition	2	3
Industry Standards Condition	1	2
Leverage Condition	1	2
Business Results Condition	2	3
Reporting Condition	2	3
Interoperability Condition	1	2

6.2.1.2.2 Care Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Care Management		
Modularity Standard	1	2
MITA Condition	2	3
Industry Standards Condition	1	2
Leverage Condition	1	2
Business Results Condition	1	2
Reporting Condition	2	3
Interoperability Condition	1	2

6.2.1.2.3 Contract Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Contract Management		
Modularity Standard	1	2
MITA Condition	2	3
Industry Standards Condition	1	2
Leverage Condition	1	2
Business Results Condition	1	2
Reporting Condition	1	2
Interoperability Condition	1	2

6.2.1.2.4 Eligibility and Enrollment Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Eligibility and Enrollment Management		
Modularity Standard	2	2
MITA Condition	2	3
Industry Standards Condition	2	2
Leverage Condition	1	2
Business Results Condition	2	3
Reporting Condition	2	3
Interoperability Condition	1	2

6.2.1.2.5 Financial Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Financial Management		
Modularity Standard	2	3
MITA Condition	2	3
Industry Standards Condition	2	2
Leverage Condition	1	2
Business Results Condition	2	3
Reporting Condition	2	3
Interoperability Condition	1	2

6.2.1.2.6 Member Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Member Management		
Modularity Standard	1	2
MITA Condition	2	3
Industry Standards Condition	1	2
Leverage Condition	1	2
Business Results Condition	1	2
Reporting Condition	1	2
Interoperability Condition	1	2

6.2.1.2.7 Operations Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Operations Management		
Modularity Standard	1	2
MITA Condition	2	3
Industry Standards Condition	1	2
Leverage Condition	1	2
Business Results Condition	2	3
Reporting Condition	2	3
Interoperability Condition	1	2

6.2.1.2.8 Performance Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Performance Management		
Modularity Standard	1	2
MITA Condition	2	3
Industry Standards Condition	1	2
Leverage Condition	1	2
Business Results Condition	1	2
Reporting Condition	2	3
Interoperability Condition	1	2

6.2.1.2.9 Plan Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Plan Management		
Modularity Standard	1	2
MITA Condition	2	3
Industry Standards Condition	1	2
Leverage Condition	1	2
Business Results Condition	1	2
Reporting Condition	2	3
Interoperability Condition	1	2

6.2.1.2.10 Provider Management Scorecard

Seven Standards and Conditions Scorecard		
MITA Business Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Business Area: Provider Management		
Modularity Standard	2	2
MITA Condition	2	3
Industry Standards Condition	2	2
Leverage Condition	1	2
Business Results Condition	2	3
Reporting Condition	2	3
Interoperability Condition	1	2

6.2.2 Information Architecture

6.2.2.1 Seven Standards and Conditions Assessment

The current overall As-Is 7Ss&Cs rating for the Information Architecture is a Level 1. The To-Be objective is a Level 3, with the understanding we must first progress through Level 2.

Modularity Standard

DMAS does not currently universally adopt data standards although it has reasonably documented the interfaces of its essential software applications. Evolving to Level 3 requires that the agency adopts data standards, documents interfaces including a full inventory, and uses intrastate standardized business rule definitions separate from core programming which aligns with Medicaid's goals regarding a transition to Level 3 in data standardization.

MITA Condition

Engaging in the self-assessment (SS-A) has allowed the organization to evaluate itself in respect to the 'To-Be' capabilities of the MITA requirements. As part of the self-evaluation process, the agency has transitioned to Level 3 by updated its SS-A for its business architecture and the seven standards and conditions for information architecture.

Industry Standards Condition

The agency does apply both HIPAA and state-specific data standards in the current environment, and it intends to continue with this practice in the coming years. The agency will also initiate efforts to apply industry or national data standards and endeavor to incorporate industry standards in data modeling techniques.

Leverage Condition

DMAS exists at Level 1 in the leverage condition by collaborating with other agencies on a limited basis and only selectively reusing data between agencies. Data exchanges tend to be ad hoc and executed with inconsistent adherence to data standards. The agency intends to move to Level 2 by evolving all of its information architecture including data storage and sharing, data access, and analytics solutions. Making the right data and, perhaps more importantly, reports dynamic, easily accessible, and secure will do a great deal to discourage data duplication and redundancy. We will then proceed to collaborate with other state agencies to implement data management and standardization of data solutions.

Business Results Condition

Although service level agreements (SLAs) are often included in contracts, data quality is rarely a component of how contractors are measured on their performance. Key performance indicators (KPIs) as well as dynamic dashboards which trend the organization's health are non-existent. Transitioning to Level 2 will require DMAS to have its analytics solution fully in place including the dynamic trending of KPIs. It is also the agency's intention to include data quality monitoring and metrics as part of its data governance initiative. To ultimately achieve Level 3, DMAS will further

improve business results by using information and data standards for automating messages where feasible and implementinginformation performance standards.

Reporting Condition

The existing transaction data is largely generated by the business processes managed through the MMIS including claims payment and processing encounters. The current system does identify and correct adjudication errors. Evolving to Level 2 and then 3 will require the agency to produce fully HIPAA compliant transaction data, standardized reporting, and performance management measurement, including information regarding intrastate transaction data and reports.

Interoperability Condition

DMAS does not have standardized transaction for non-HIPAA data exchanges. Nor does it standardize any intra-system services. By moving to a SOA based architecture, DMAS intends to standardize information exchange through standardized services. Lastly, DMAS has not yet brought in electronic clinical records for its recipients which means that the organization currently does not coordination with HIE or any other agencies as part of interoperability with other agencies. It is the goal of the agency to transition to Level 2 by identifying areas where it interacts with the exchange or HIE or any other agencies to allow interoperability. Doing so will expand the types of data accessible on Medicaid recipients and would greatly enhance our ability to understand public health trends. Once established, these capabilities will be leveraged to fully adopt the MITA Framework and industry and national standards to support interoperability with other state agencies.

6.2.2.2 Information Architecture 7Ss&Cs Scorecard

Seven Standards and Conditions Scorecard		
Information Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Overall Assessment Level	1	3
Modularity Standard	1	3
MITA Condition	2	3
Industry Standards Condition	2	3
Leverage Condition	1	3
Business Results Condition	1	3
Reporting Condition	1	3
Interoperability Condition	1	3

6.2.3 Technical Architecture

6.2.3.1 Seven Standards and Conditions Assessment

The overall As-Is 7Ss&Cs rating for the Technical Architecture is a Level 1. The To-Be objective is a Level 3.

Modularity Standard

DMAS plans to leverage the existing Enterprise Service Bus (ESB) and BPM products to implement service oriented architecture principles by creating stateless, granular, autonomic, reusable, loosely coupled services with canonical service contracts across most of its business areas.

MITA Condition

By DMAS performing the SS-A for the technical architecture, this has permitted the organization to evaluate itself in respect to the 'To-Be' capabilities of the MITA 7Ss&Cs. As part of the self-evaluation process, DMAS plans to transition to Level 3. The agency will leverage the existing BPM product to automate most of the business processes by orchestrating modularized services using Business Process Execution Language (BPEL).

Industry Standards Condition

DMAS plans to develop a secure, responsive online portal with single sign-on and role base authorization for leveraging the managed file transfer to implement X12 and NIEM (National Information Exchange Model) standards for exchanging information.

Leverage Condition

DMAS exists at Level 1 in the leverage condition by collaborating with other agencies on a limited basis and only selectively reusing data between agencies. DMAS plans to leverage the enterprise service bus and message queues for exchange of information between external entities using canonical interfaces and also to leverage the rules engine to implement the dynamic business functions.

Business Results Condition

In order to obtain the planned Level 3, DMAS plans to implement automated workflow for most of the business areas to reduce the latency and improve efficiency and accountability. Additionally, DMAS plans to develop a DataMart to track and enforce SLAs.

Reporting Condition

DMAS plans leverage the current data warehouses and also add additional DSS capabilities by a DataMart to produce reports that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.

Interoperability Condition

In order to obtain the planned Level 3 for this condition, DMAS plans to use canonical interfaces in the modular web services for information exchange internally and externally.

6.2.3.2 Technical Architecture 7Ss&Cs Scorecard

Seven Standards and Conditions Scorecard		
Technical Architecture	***As-Is Level of S&C Capability***	***To-Be Level of S&C Capability***
Overall Assessment Level	1	3
Modularity Standard	1	3
MITA Condition	1	3
Industry Standards Condition	2	3
Leverage Condition	1	3
Business Results Condition	1	3
Reporting Condition	1	3
Interoperability Condition	1	3

7.0 ASSESSMENT SUMMARY

This section contains a variety of summaries of the assessment results.

Because the Information and Technical architectures were assessed at the enterprise level, there is only a single summary for those areas. However, the Business Architecture can be summarized by business area, and there are charts below to reflect that.

However, the assessment results ultimately are not viewed as just so many numbers. Rather, the assessment provides an overall sense of DMAS's current capability levels relative to the MITA 3.0 Framework and helps to begin our planning and definition for what we want to request as we develop the requirements for replacing our current MMIS with a Medicaid Enterprise System.

7.1 BUSINESS ARCHITECTURE SUMMARIES

Figure 7.1-1 shows the overall As-Is and To-Be ratings for all of the Business areas.

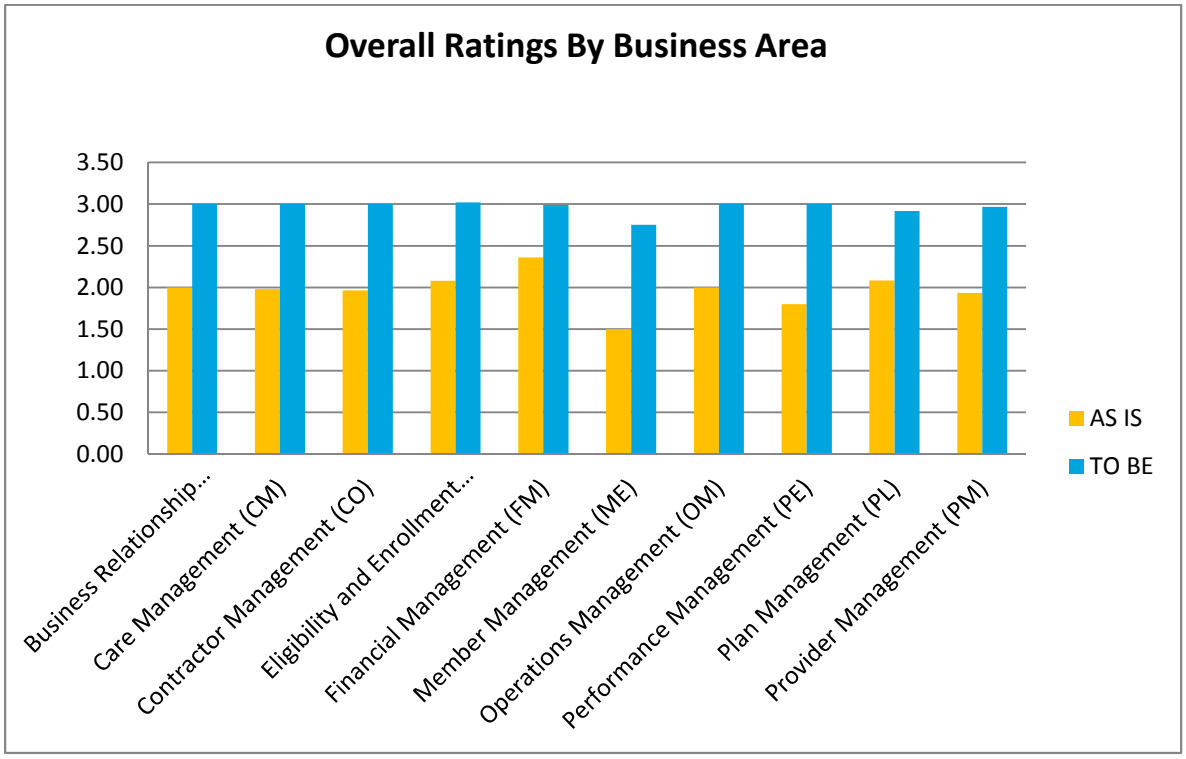


Figure 7.1-1 Overall Ratings by Business Area

Figure 7.1-2 shows the aggregated As-Is and To-Be capability levels across all ten Business Areas.

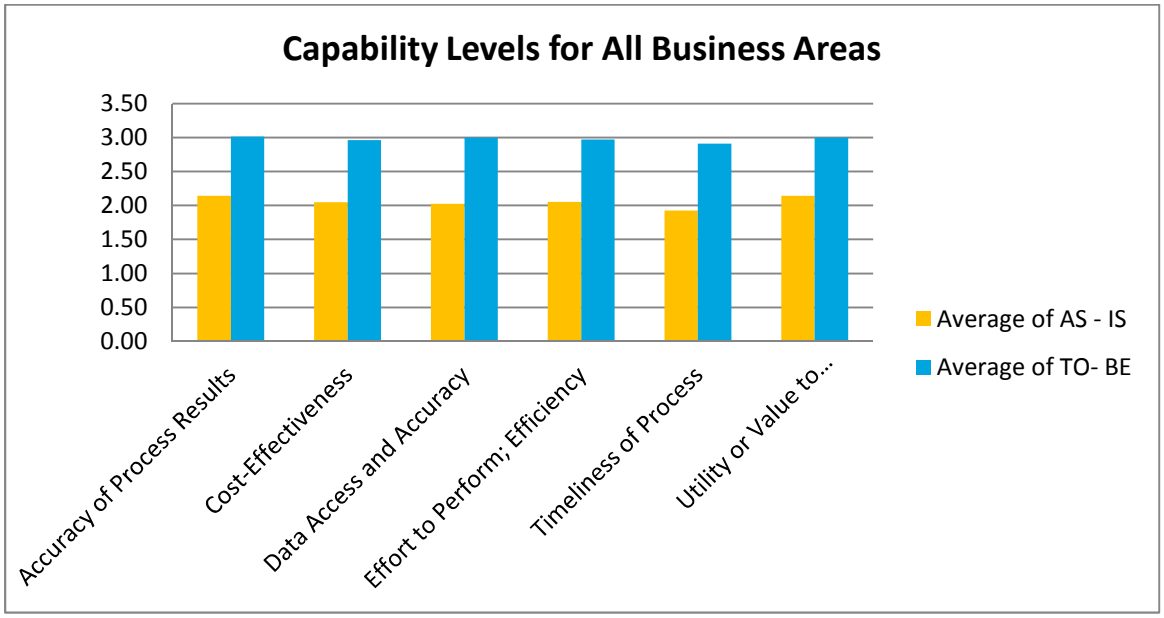


Figure 7.1-2 Aggregated Capability Levels for All Business Areas

7.1.1 Business Area Summaries

Figures 7.1.1-1 through 7.1.1-10 summarize the As-Is and To-Be capability ratings for the business processes within each of the ten Business Areas.

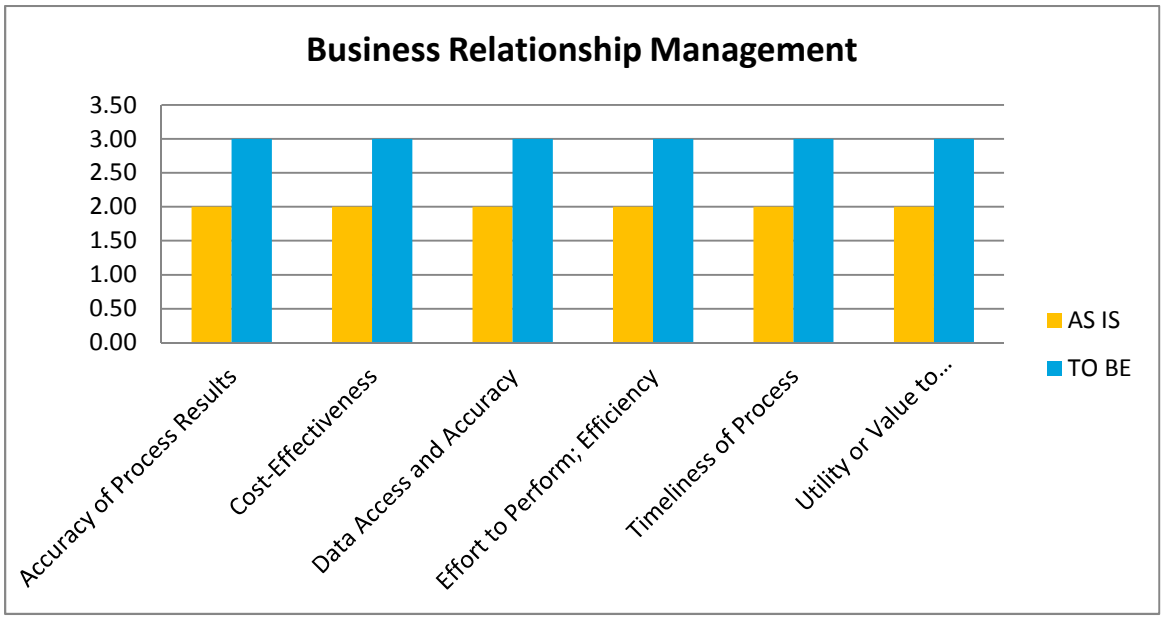


Figure 7.1.1-1 Business Relationship Management

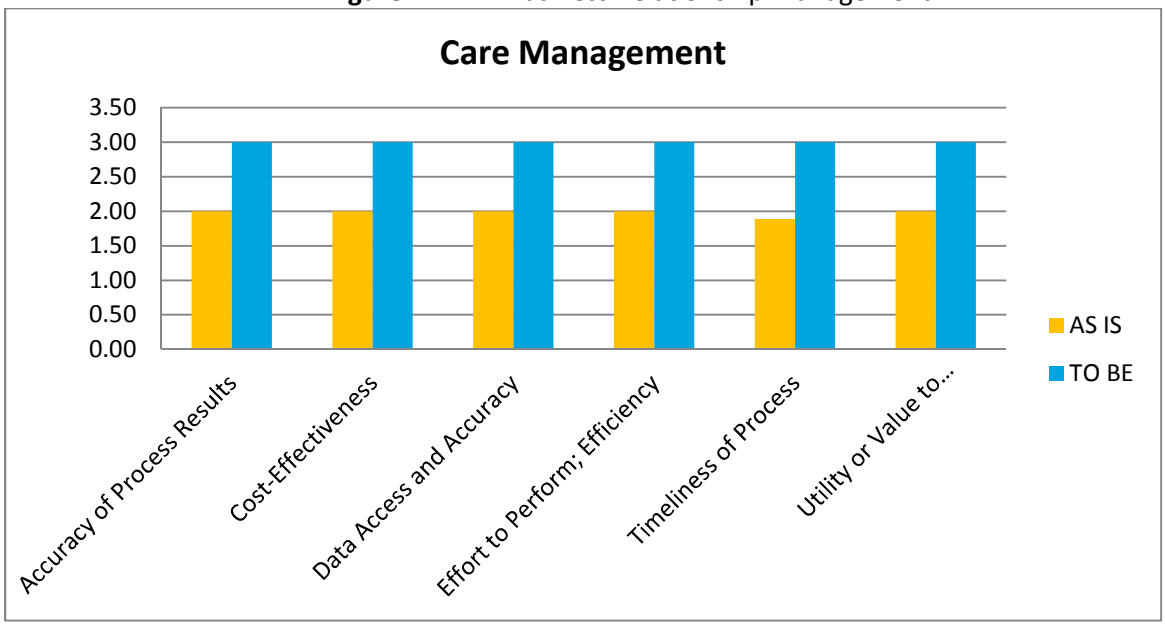


Figure 7.1.1-2 Care Management

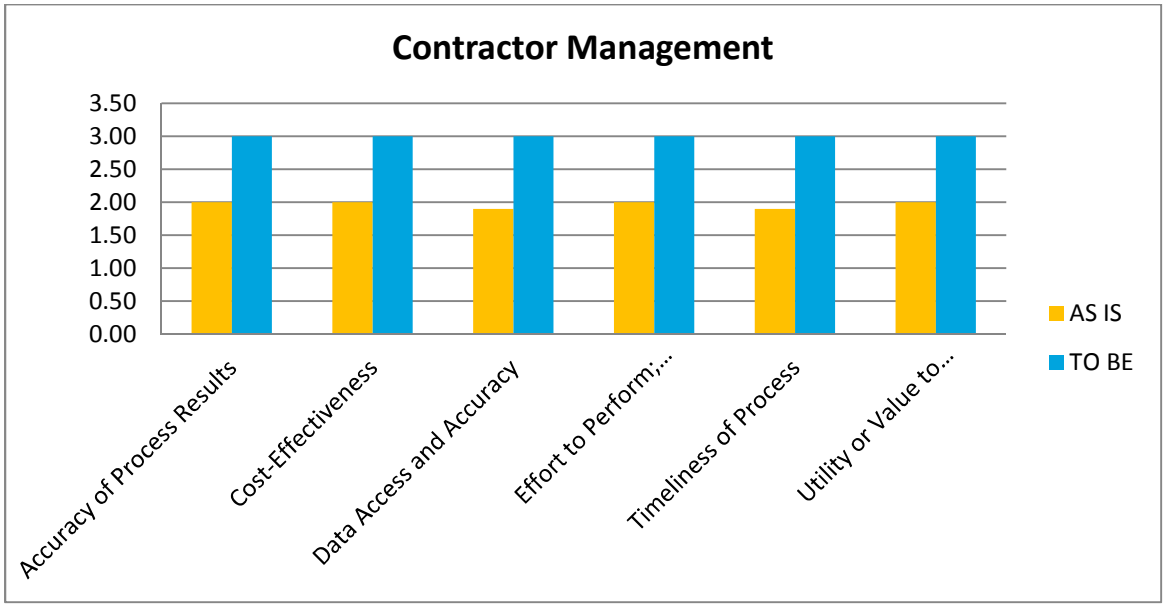


Figure 7.1.1-3 Contractor Management

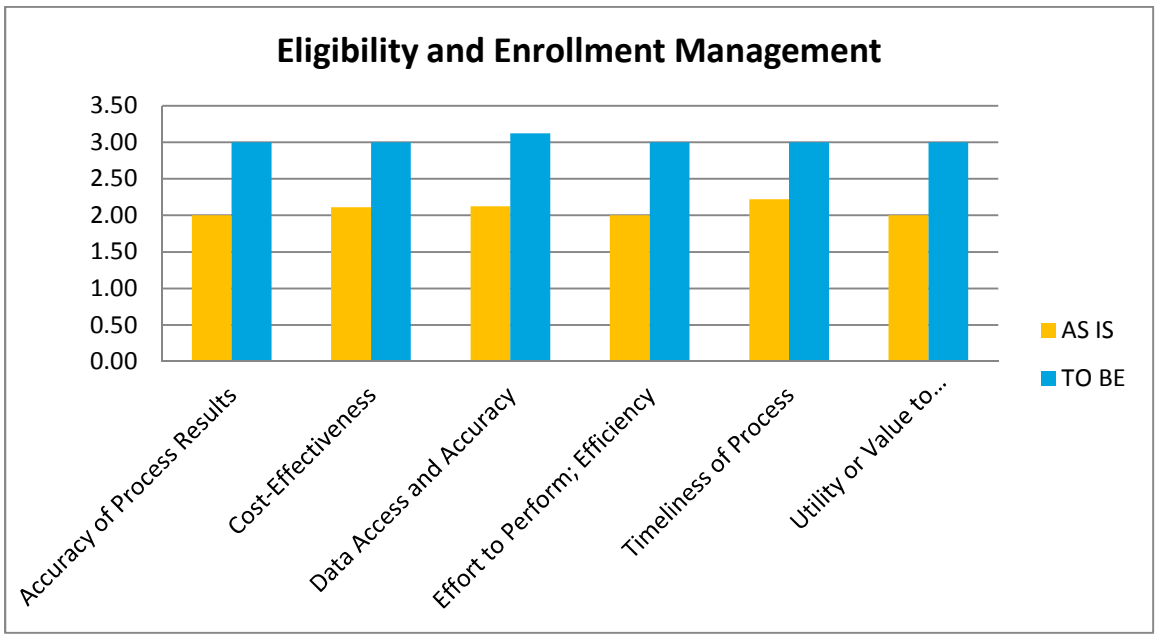


Figure 7.1.1-4 Eligibility and Enrollment Management

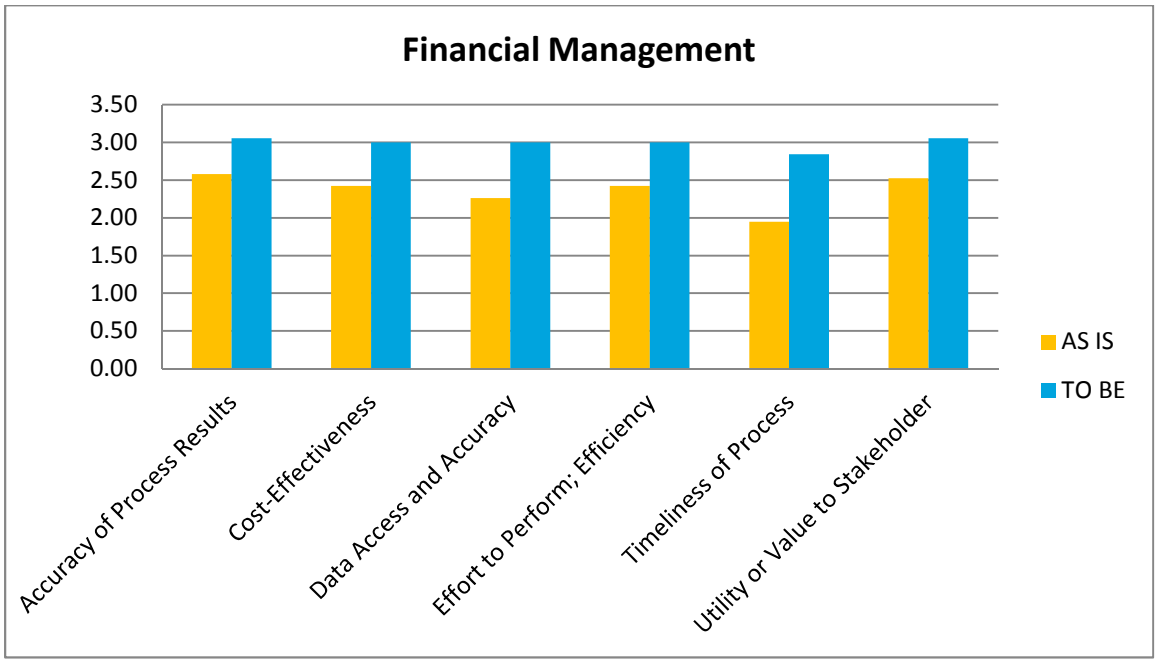


Figure 7.1.1-5 Financial Management

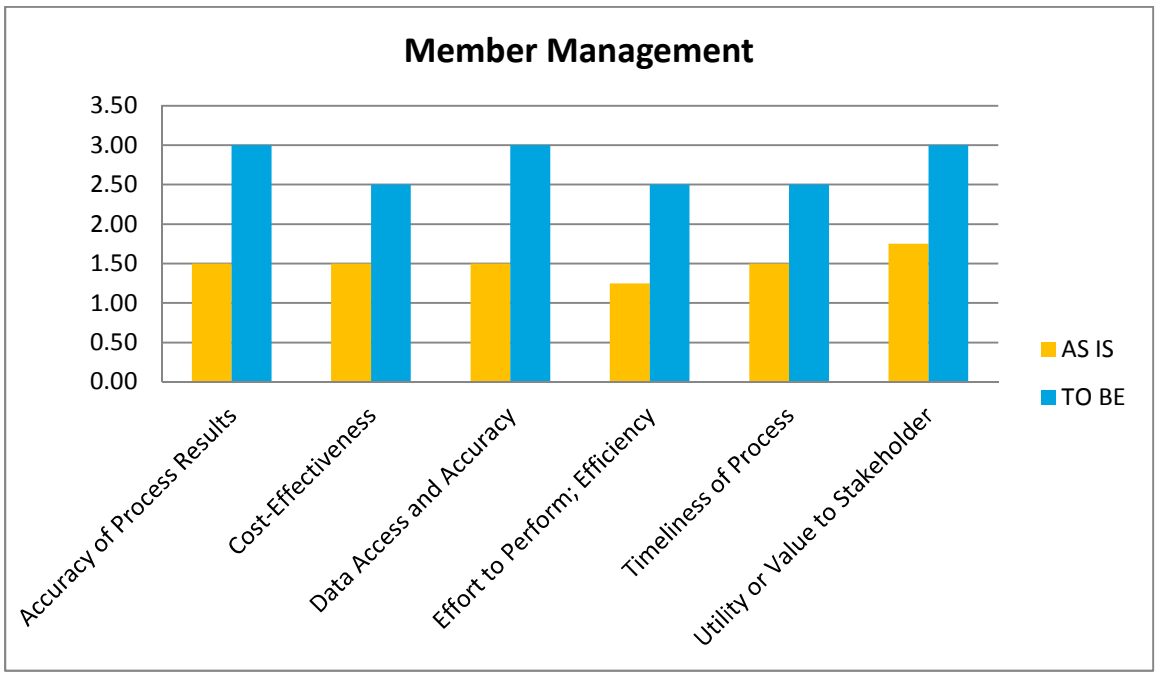


Figure 7.1.1-6 Member Management

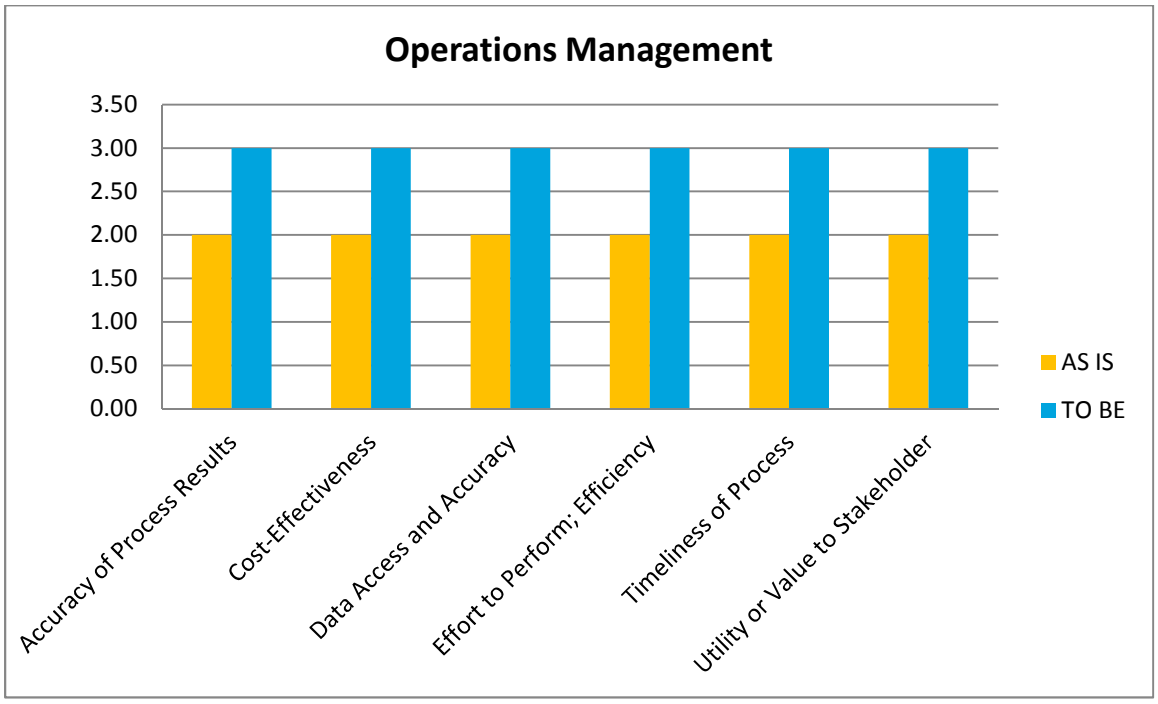


Figure 7.1.1-7 Operations Management

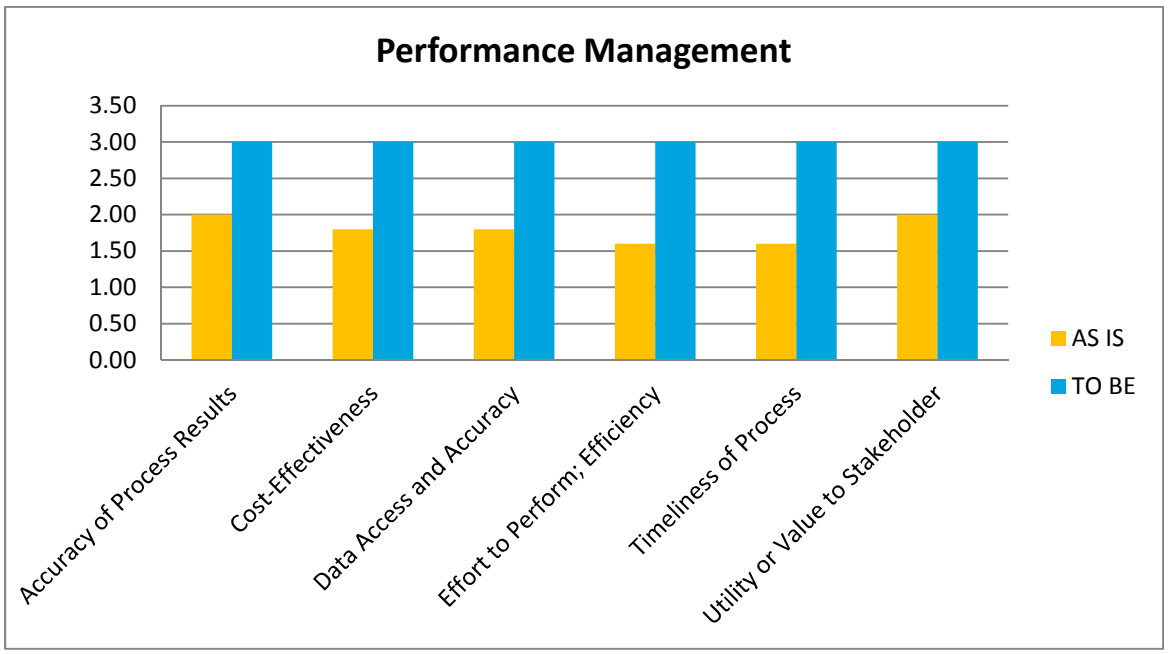


Figure 7.1.1-8 Performance Management

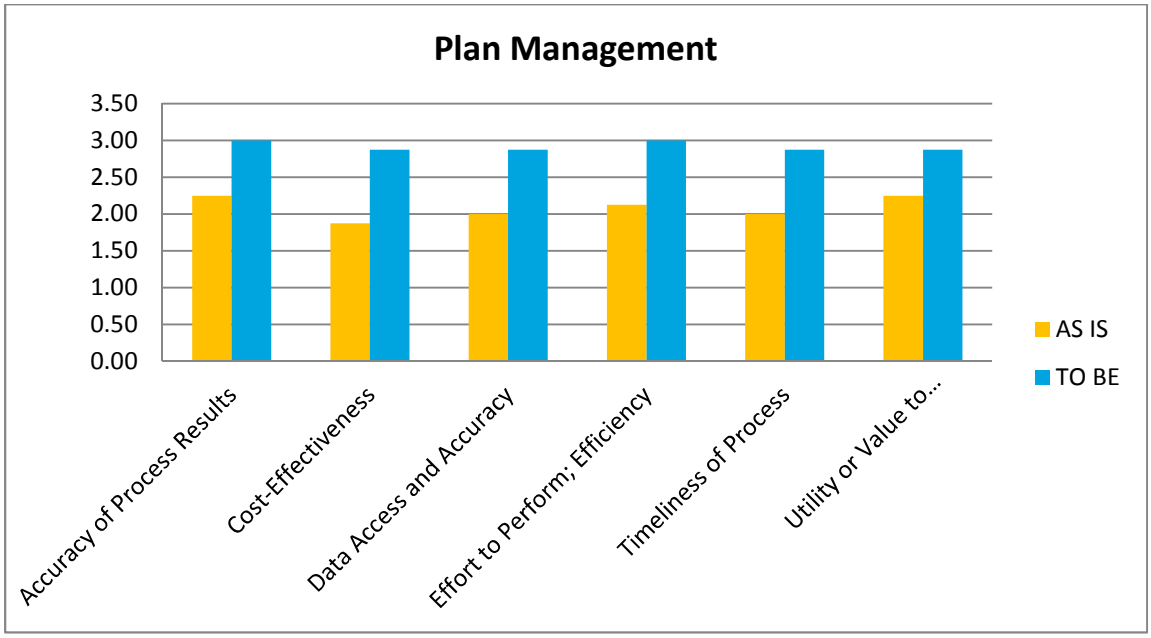


Figure 7.1.1-9 Plan Management

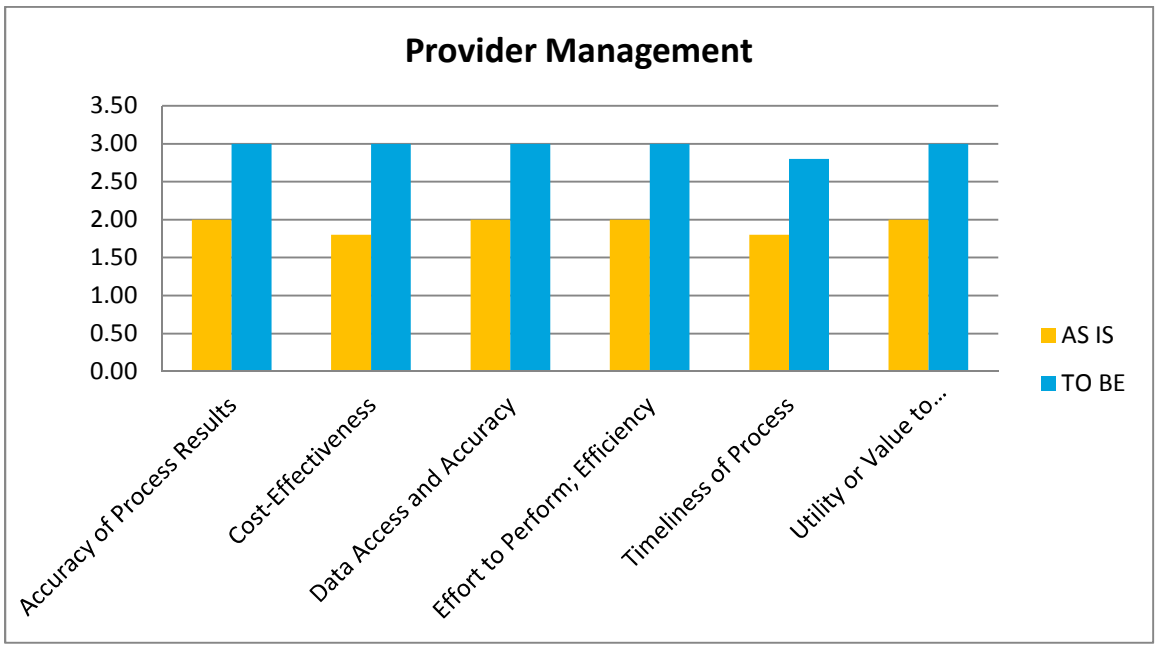


Figure 7.1.1-10 Provider Management

7.1.2 Business Category Summaries

Table 7.1.2-1, which appears at the end of this section, provides a further level of summary by reporting the average for each capability within the twenty-one business categories.

7.2 INFORMATION ARCHITECTURE SUMMARY

Figure 7.2-1 shows a summary of the As-Is and To-Be capabilities for the Information Architecture.

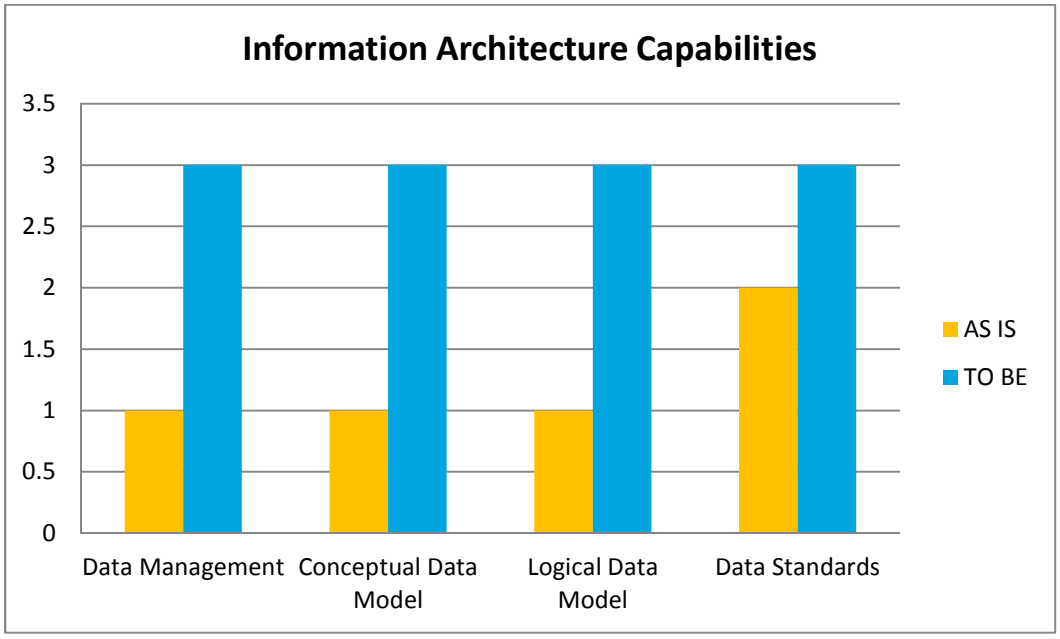


Figure 7.2-1 Information Architecture Capabilities

7.3 TECHNICAL ARCHITECTURE SUMMARY

Figure 7.3-1 shows a summary of the As-Is and To-Be capabilities for the Technical Architecture.

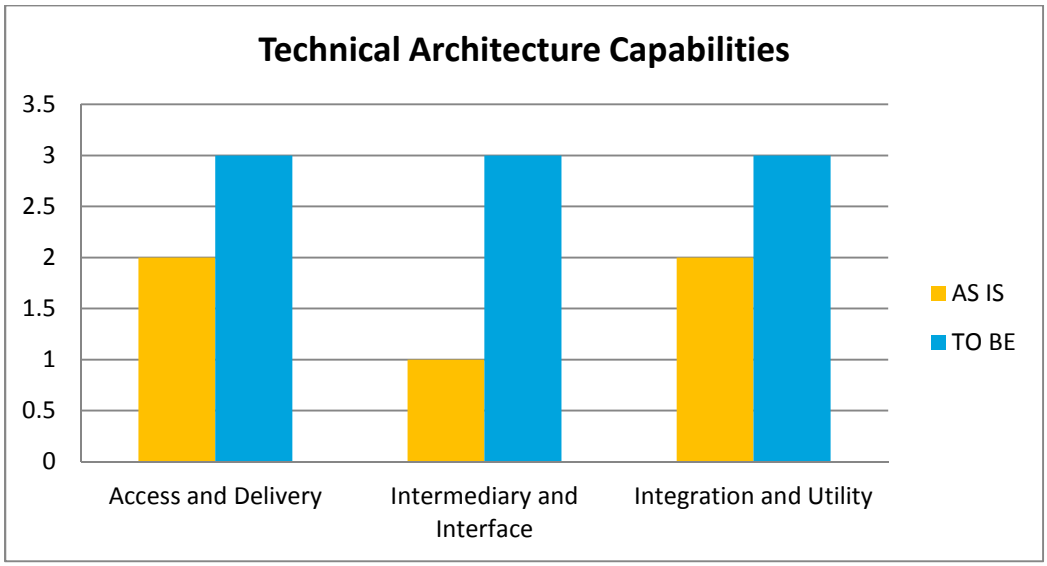


Figure 7.2-1 Technical Architecture Capabilities

7.4 SEVEN STANDARDS AND CONDITIONS SUMMARY

Figure 7.4-1 shows a summary of the seven standards and conditions As-Is and To-Be capabilities for all three architectures.

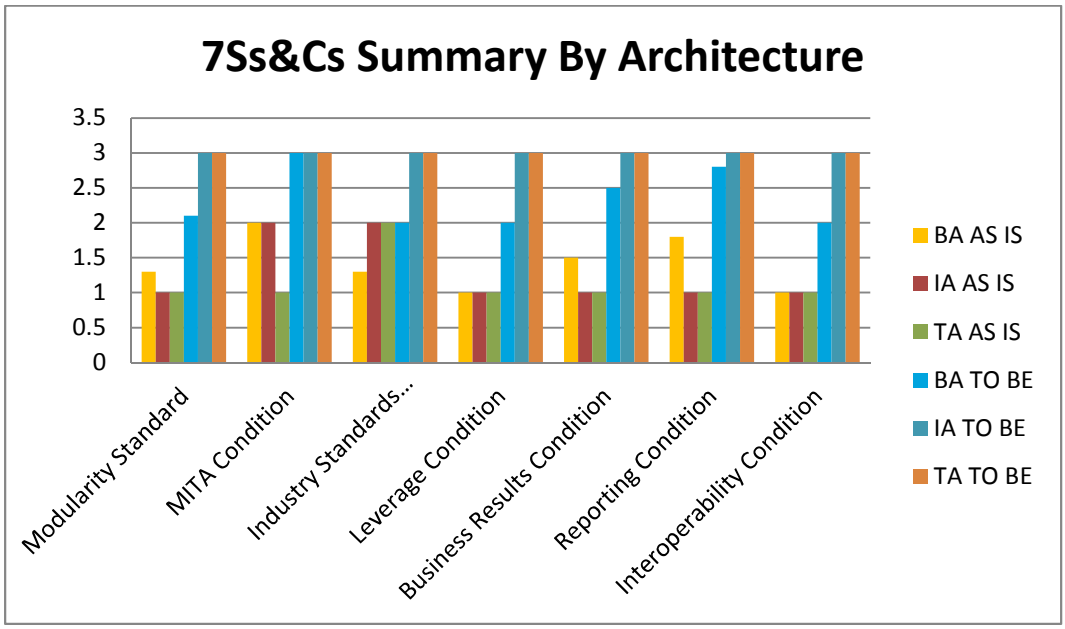


Figure 7.4-1 7Ss&Cs Capabilities by Architecture

Table 7.1.2-1 – Summary by Business Category

Business Area/Business Category/Capability	As-Is (Avg)	To-Be (Avg)
Business Relationship Management (BR)	**2.00**	**3.00**
Standards Management	**2.00**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00
Care Management (CM)	**1.98**	**3.00**
Authorization Determination	**2.00**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00
Case Management	**1.97**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	1.80	3.00
Utility or Value to Stakeholder	2.00	3.00

Business Area/Business Category/Capability	As-Is (Avg)	To-Be (Avg)
Contractor Management (CO)	**1.96**	**3.00**
Contractor Information Management	**1.92**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	1.50	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00
Contractor Management	**2.00**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00
Contractor Support	**1.94**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	1.67	3.00
Utility or Value to Stakeholder	2.00	3.00
Eligibility and Enrollment Management (EE)	**2.14**	**3.06**
Member Enrollment	**2.28**	**3.12**
Accuracy of Process Results	2.25	3.00
Cost-Effectiveness	2.25	3.25
Data Access and Accuracy	2.25	3.00
Effort to Perform; Efficiency	2.25	3.25
Timeliness of Process	2.40	3.00
Utility or Value to Stakeholder	2.25	3.25
Provider Enrollment	**2.00**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00

Business Area/Business Category/Capability	As-Is (Avg)	To-Be (Avg)
Financial Management (FM)	**2.33**	**2.98**
Accounts Payable Management	**2.50**	**3.06**
Accuracy of Process Results	2.67	3.17
Cost-Effectiveness	2.67	3.00
Data Access and Accuracy	2.33	3.00
Effort to Perform; Efficiency	2.67	3.17
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.67	3.00
Accounts Receivable Management	**2.19**	**2.96**
Accuracy of Process Results	2.50	3.00
Cost-Effectiveness	2.25	3.00
Data Access and Accuracy	2.13	3.00
Effort to Perform; Efficiency	2.25	3.00
Timeliness of Process	1.88	2.75
Utility or Value to Stakeholder	2.13	3.00
Fiscal Management	**2.38**	**2.92**
Accuracy of Process Results	2.50	3.00
Cost-Effectiveness	2.25	3.00
Data Access and Accuracy	2.50	3.00
Effort to Perform; Efficiency	2.25	2.75
Timeliness of Process	2.00	2.75
Utility or Value to Stakeholder	2.75	3.00
Member Management (ME)	**1.50**	**2.75**
Member Information Management	**1.50**	**2.67**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	1.00	2.00
Data Access and Accuracy	1.00	3.00
Effort to Perform; Efficiency	1.00	2.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00
Member Support	**1.50**	**2.78**
Accuracy of Process Results	1.33	3.00
Cost-Effectiveness	1.67	2.67
Data Access and Accuracy	1.67	3.00
Effort to Perform; Efficiency	1.33	2.67
Timeliness of Process	1.33	2.33
Utility or Value to Stakeholder	1.67	3.00

Business Area/Business Category/Capability	As-Is (Avg)	To-Be (Avg)
Operations Management (OM)	**2.00**	**3.00**
Claims Adjudication	**2.00**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00
Payment and Reporting	**2.00**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00
Performance Management (PE)	**1.80**	**3.00**
Compliance Management	**1.80**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	1.80	3.00
Data Access and Accuracy	1.80	3.00
Effort to Perform; Efficiency	1.60	3.00
Timeliness of Process	1.60	3.00
Utility or Value to Stakeholder	2.00	3.00

Business Area/Business Category/Capability	As-Is (Avg)	To-Be (Avg)
Plan Management (PL)	**2.08**	**2.92**
Health Benefits Administration	**2.11**	**3.00**
Accuracy of Process Results	2.33	3.00
Cost-Effectiveness	1.67	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.33	3.00
Utility or Value to Stakeholder	2.33	3.00
Health Plan Administration	**2.50**	**3.00**
Accuracy of Process Results	2.50	3.00
Cost-Effectiveness	2.50	3.00
Data Access and Accuracy	2.50	3.00
Effort to Perform; Efficiency	2.50	3.00
Timeliness of Process	2.50	3.00
Utility or Value to Stakeholder	2.50	3.00
Plan Administration	**1.78**	**2.78**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	1.67	2.67
Data Access and Accuracy	1.67	2.67
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	1.33	2.67
Utility or Value to Stakeholder	2.00	2.67
Provider Management (PM)	**1.93**	**2.97**
Provider Information Management	**2.00**	**3.00**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	2.00	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	2.00	3.00
Utility or Value to Stakeholder	2.00	3.00
Provider Support	**1.89**	**2.94**
Accuracy of Process Results	2.00	3.00
Cost-Effectiveness	1.67	3.00
Data Access and Accuracy	2.00	3.00
Effort to Perform; Efficiency	2.00	3.00
Timeliness of Process	1.67	2.67
Utility or Value to Stakeholder	2.00	3.00
Average for All Capabilities	**2.05**	**2.98**