Commonwealth of Pennsylvania
Department of Public Welfare (DPW)

Medicaid Information Technology Architecture (MITA)
State Self-Assessment (SS-A) V 3.0 Project

RFQ# 6100023657

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1.0 EXECUTIVE SUMMARY

Cognosante is under contract to the Commonwealth of Pennsylvania, Department of Public Welfare (DPW) to provide consulting services for the Medicaid Information Technology Architecture (MITA) 3.0 State Self-Assessment (SS-A).

1.1 Deliverable Document Overview

This document is organized into eight (8) major sections:

1. **Executive Summary –** Briefly presents the main topics discussed in the document including a MITA overview, a MITA Assessment project overview, the Executive Guiding Principles, and a Summary of Findings of both the business and technical assessment.
2. **DPW Medicaid Enterprise SS-A Overview –** Describes the overall MITA SS-A project and the methodologies utilized.
3. **MITA SS-A Business Assessment Results** – Presents the results of the Business Assessment within the ten Business Areas at the Business Process level. This includes the As Is and To Be maturity assessments for each Business Process.
4. **MITA SS-A Technical and Information Assessment Results:** Presents the results of the As Is technical and information assessment. This includes the identification, definition, and diagram of the primary systems supporting the enterprise and the presentation of maturity assessments for these systems relative to fifteen (15) technical functions and seven (7) information capabilities, and technical recommendations structured around the Centers for Medicare & Medicaid Services (CMS) Seven Conditions and Standards (7C&S).
5. **MITA Gap Analysis –** Outlines the summary gaps between As Is and To Be maturity for each MITA Business Area and the general approach to bridging those gaps as part of MITA transition planning.
6. **MITA To Be Roadmap –** Discusses the efforts already underway within the Enterprise, major To Be themes emerging from the SS-A, and definition of the overall To Be strategy and the proposed projects that will encompass MITA transition activities.
7. **Conclusion –** Contains a short summary of the Pennsylvania MITA 3.0 Update Project.
8. **Appendices –** Contains detailed supporting documentation for key assessment findings.

1.2 MITA Overview

MITA is a business initiative of the CMS in cooperation with state programs, intended to stimulate an integrated business and technological transformation of the Medicaid enterprise in all states. The MITA Framework 3.0 is a consolidation of principles, business and technical models, and guidelines that creates a template that states may use to develop their individual enterprise architectures. In the future, MITA guidelines will support states' requests for appropriate Federal Financial Participation (FFP) for Medicaid Enterprise systems such as the Medicaid Management Information System (MMIS).

MITA is intended to provide a business, technical, and information architecture (IA) that states can use as a framework for improving Medicaid by standardizing processes and exchanging data throughout the enterprise. Affected stakeholders might include members, vendors and service providers, state and federal Medicaid agencies, and other agencies and programs that are supported by federal matching funds.

MITA identifies common Medicaid business processes and seeks to automate them into web services. Web services encompass standards that enable automated applications to communicate and exchange data

over the internet (or intranet) across many sites and organizations. The development of common data and information standards allows interoperability across different platforms, integration of applications, and modular programming so changes can be introduced incrementally and existing information assets can be leveraged. MITA entails far more than paying and documenting claims; it envisions significant business processing, information, and technical changes:

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

This conceptual transformation entails changing to a Service-Oriented Architecture (SOA) that is nationally interoperable. Some changes can be made in less than 5 years. Others will take 5-10 years largely because defining scope changes related to longer-term strategies are dependent upon technologies and business processes that do not exist today or have not yet fully evolved by DPW or CMS. Additionally, like many states, budget shortfalls in the Commonwealth could alter DPW's prioritized project needs.

1.3 MITA SS-A

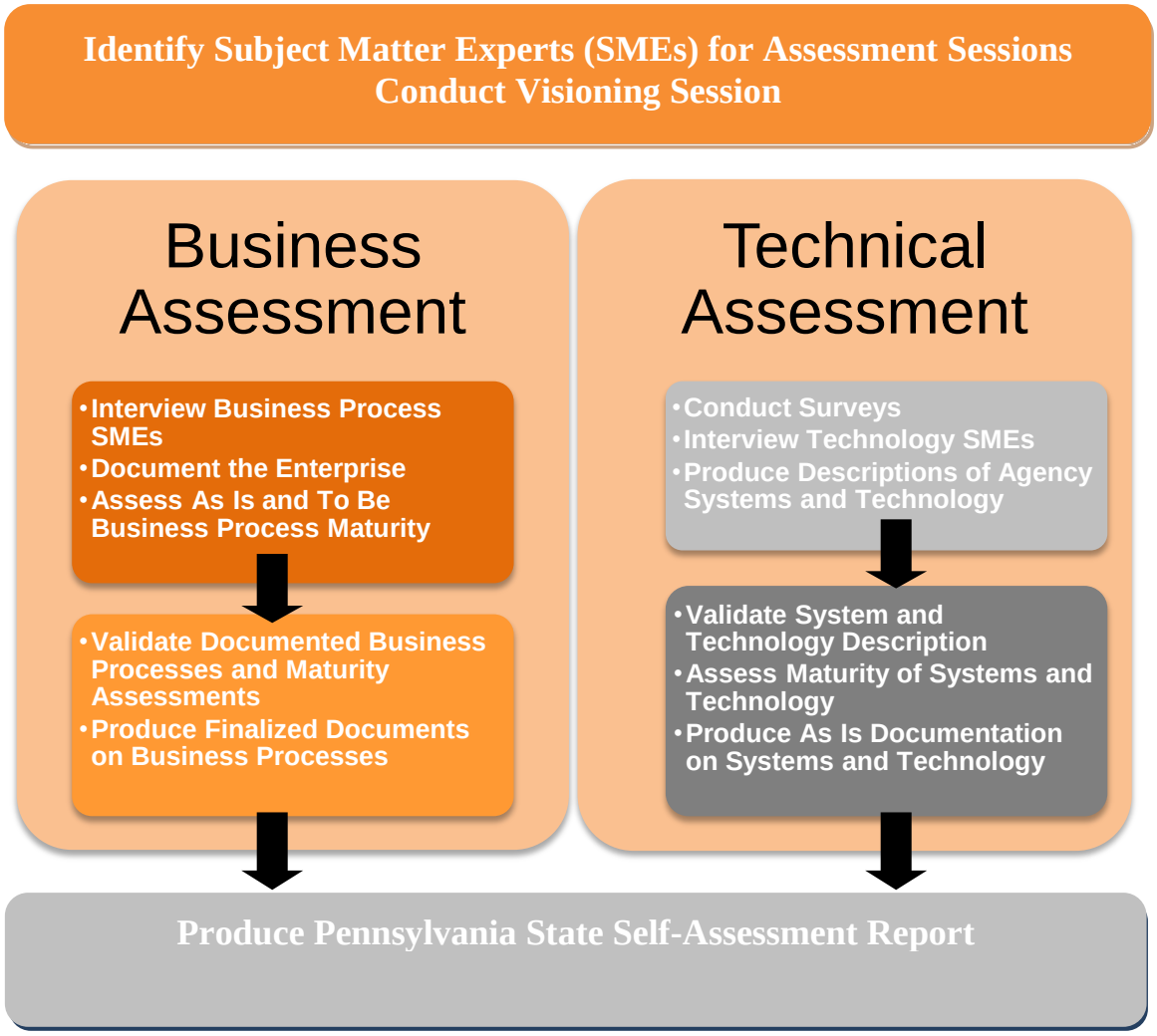
1.3.1 Background

The project consisted of the following tasks to update the Enterprise's MITA SS-A:

- Conducted executive visioning sessions (EVSs) to review and update DPW's goals for the future
- Validated and updated DPW previous As Is Assessment that was completed by the Enterprise in June 2011. This was completed using MITA framework version 2.01 and required update to version 3.0.
- Cognosante conducted MITA sessions and surveys by DPW staff to review, validate, and update the MITA As Is SS-A completed in 2011. Session participants included Subject Matter Experts (SMEs) from each of the 10 MITA business areas.
- Cognosante distributed online technical surveys to gather system capabilities and criteria. Survey responses were collected, compiled, and used to support the technical assessment.
- Cognosante conducted MITA To Be sessions to confirm understanding of the Enterprise's vision for progression through MITA Maturity Levels (MMLs)
- Cognosante conducted MITA To Be sessions with leadership to clarify and confirm the assessment levels for each business area
- Delivered an updated DPW MITA SS-A which included:
  - Business Assessment and Technical Assessment
  - Updated MITA As Is and To Be Assessment
  - MITA Gap Analysis
  - MITA Roadmap that documents a blueprint for business and functional improvements to Pennsylvania's Medicaid Program

An overview of the DPW Medicaid SS-A process is provided in Figure 1.

Figure 1: Description of the MITA SS-A Process



1.3.2 Description of the MITA SS-A Process

MITA provides states with an IA that they can use as a framework for improving Medicaid and exchanging data throughout the enterprise, including members, vendors and service providers, state and federal Medicaid agencies, and other agencies and programs that are supported by federal matching funds. While Medicaid agencies rely substantially on technology to operate, the MITA framework envisions changes that will enable the Medicaid business processes to drive the technological changes over the next decade. In assuming that many business processes might be similar among the various states, some economies of scale might be realized if these processes can be modeled and shared among states. The MITA vision is articulated as follows:

> "*Establish a national framework of enabling technologies and processes that support improved program administration for the Medicaid enterprise and for stakeholders dedicated to improving health care outcomes and administrative procedures for Medicaid Members.*" [1]

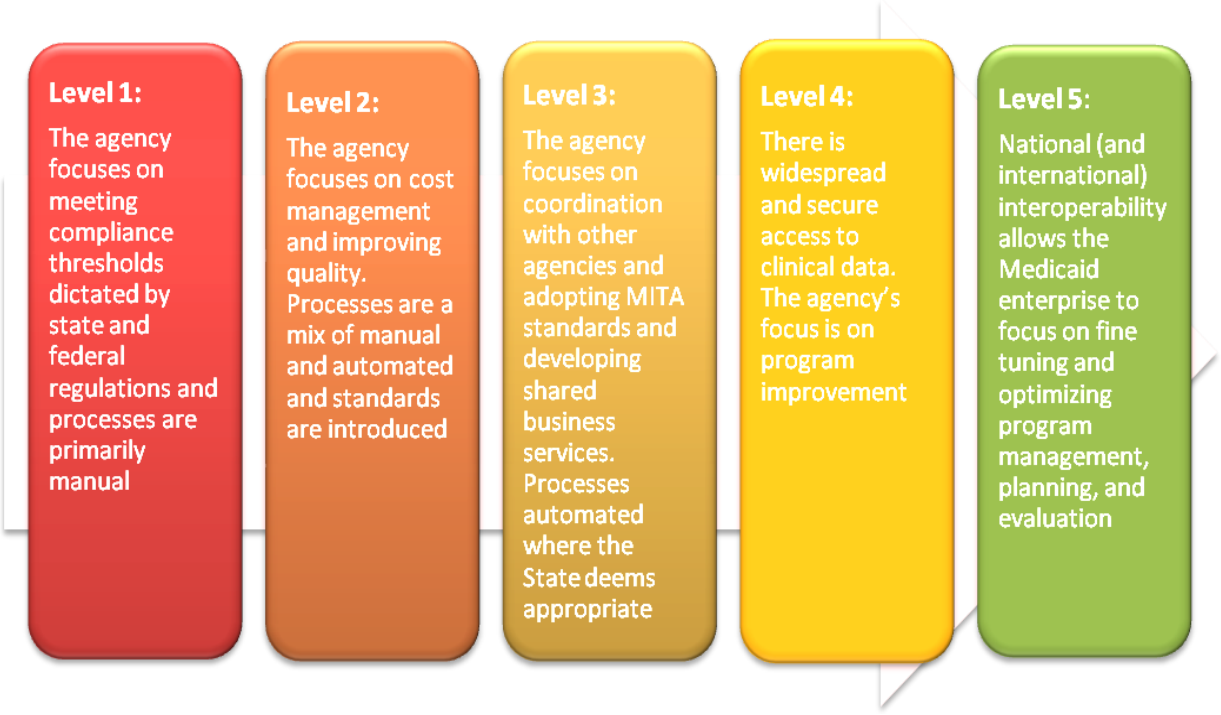
[1] Source: MITA Framework v3.0, Front Matter – Overview of MITA Initiative, p. 9

CMS established the MITA framework, which elaborated on the MITA vision. That framework adopted the best practices in the industry to meet the unique requirements of Medicaid. The framework details that MITA includes a Business Architecture (BA), an IA, and a Technical Architecture (TA) that work in concert to define and improve the administration of Medicaid enterprises.

- The BA includes all of the business processes defined by the Medicaid Agency and their associated MMLs for each of them. The BA is the most robust portion of the MITA framework.
- The IA defines the data and standards necessary to conduct these business operations. The IA has improved structure in the Framework 3.0. All of the concepts in the framework allow individual Medicaid agencies the options and flexibility to pursue their own Enterprise Architecture, while still adhering to the basic principles that move the entity forward on the continuum to more mature capabilities that better meet the established goals and objectives.
- The TA establishes fundamental concepts of technology, such as interoperability, modularity, and flexibility, without naming specific technology or systems.

Fundamental to implementation of the MITA concept is the requirement for each state to conduct an annual SS-A update. Within the SS-A, each state is to carefully and honestly look at its current business processes to establish which ones pertain to its Medicaid operations and at what MML that business process is – the As Is state. The capabilities of a process at each MML are specific to that process. However, these capabilities can be generalized, as shown in Figure 2.

Figure 2: MML Summary



Once the As Is Maturity is determined, the SS-A requires them to consider where it would like to be over a period of time. This is the To Be Maturity Level for each business process. While MITA typically looks at a 5- to 10-year timeframe, each state determines its own time period.

States must address the issues between the As Is and the To Be before they can progress to the higher maturity. Those issues represent the gaps. As a state defines the To Be Maturity Level, it must also

elaborate on the functionality it needs to accomplish that maturity. The functionality can represent both business process requirements and technical requirements to achieve that goal.

1.3.3 Overview of the Commonwealth of Pennsylvania Medicaid Enterprise (PME)

MITA is a plan to transform Medicaid. The first step is to define the Commonwealth's Medicaid Enterprise. The Medicaid Enterprise generally includes the Medicaid agency and ancillary agencies and programs sharing or utilizing health services.

In its April 2011 Medicaid Information Technology (IT) Supplement (MITS), CMS defines the Medicaid Enterprise as follows:

> *"The Medicaid enterprise is comprised of the states, the federal government, and stakeholders who are directly and indirectly part of the administration and health care delivery ecosystem.[2]"*

The primary entity responsible for Medicaid within the Commonwealth of Pennsylvania is the DPW. The organizational structure outlined below only shows those entities that have a direct impact to the Medicaid Enterprise:

- Office of Legislative Affairs (OLA)
- Office of Licensing and Regulatory Management (OLRM)
- Office of Policy Development (OPD)
- Office of Press and Communications (OPC)
- Office of Administration (OA)
  - Bureau of Financial Operations (BFO)
  - Bureau of Information Systems (BIS)
  - Bureau of Administrative Services (BAS)
  - Bureau of Hearings and Appeals (BHA)
  - Bureau of Program Integrity (BPI)
- Office of Income Maintenance (OIM)
  - Bureau of Operations (BO)
  - Bureau of Program Support (BPS)
  - Bureau of Policy (BP)
  - Bureau of Program Evaluation (BPE)
  - Bureau of Employment and Training Programs (BETP)
  - Bureau of Child Support Enforcement Programs (BCSEP)
- Office of Medical Assistance Programs (OMAP) (Medicaid Entity)
  - Bureau of Data and Claims Management (BDCM)
  - Bureau of Managed Care Operations (BMCO)
  - Bureau of Policy, Analysis, and Planning (BPAP)
  - Bureau of Fee-for-Service Programs (BFFSP)
- Office of Mental Health and Substance Abuse Services (OMHSAS)
  - Bureau of Community and Hospital Operations
  - BP, Planning, and Program Development
  - Bureau of Financial Management and Administration
  - Bureau of Children's Behavioral Health
  - Bureau of Quality Management and Data Review
- Office of Developmental Programs (ODP)

[2] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf

- Bureau of Financial Management and Budget
- Bureau of Supports for People with Intellectual Disabilities
- BP and Program Support
- Bureau of Autism Services (BAS)

- Office of Children, Youth, and Families (OCYF)
  - BP, Programs, and Operations
  - Bureau of Children and Family Services
  - Bureau of Juvenile Justice Services
  - Bureau of Budget and Fiscal Support
- Office of Long-Term Living (OLTL)
  - Bureau of Finance
  - Bureau of Provider Support (BPS)
  - Bureau of Community Development
  - Bureau of Individual Support
- Office of Child Development and Early Learning (OCDEL) (Shared with the Pennsylvania Department of Education (PDE))
  - Bureau of Subsidized Child Care Services
  - Bureau of Certification Services
  - Bureau of Early Learning Services
  - Bureau of Intervention Services

While the majority of Medicaid activities occur within DPW's OMAP, the SS-A is used to identify internal entity relationships outside of OMAP. These entities provide a look at the relationships and interdependencies within other Commonwealth areas of business to accomplish the mission of Medicaid. Other entities include but are not limited to:

- Pennsylvania Department of Aging (PDA)
- Department of Banking
- PDE
- Department of Health (DOH)
- Department of Military and Veteran's Affairs (DMVA)
- Department of State (DOS)
- Department of Revenue (DOR)
- Pennsylvania Insurance Department (PID)
  - State Children's Health Insurance Program (SCHIP)
- Governor's Office of Administration
- Office of Clinical Quality Improvement (OCQI)
- Office of the Attorney General (OAG)
- DPW
  - Office of General Counsel (OGC)
  - Office of Budget (OB)
  - Office of Policy
  - County Health, Aging, and Welfare Offices
  - Office of the Inspector General (OIG)
- State Inspector General
- Office of Information Technology (OIT)

Medicaid activities also rely on external interfaces and initiatives that have influence on the PME. These interfaces and initiatives include:

- Social Security Administration (SSA)
- Internal Revenue Service (IRS)
- Center for Disease Control (CDC)
- CMS
- Drug Enforcement Agency (DEA)
- Federal Department of Health and Human Services (DHHS)
- Office of the National Coordinator (ONC)
- State Medicaid Health Information Technology (HIT) Plan (SMHP)
- American Recovery and Reinvestment Act (ARRA)
- Patient Protection Affordable Care Act (PPACA)
- Regional Health Information Organization (RHIO)
- Standards Development Organization (SDO)
- Hewlett-Packard Enterprise Services (HPES)

1.3.4 Participants

DPW management and project leadership identified SMEs from their staff, including appropriate Contractors that have key roles in a specific business process. The SMEs are listed in each individual Business Process template included in Appendix B: MITA SS-A Details.

1.3.5 Executive Vision

The DPW Medicaid Vision Statement plays a pivotal role in defining the future direction and state of the Medicaid Enterprise. The vision is the catalyst for the next level of strategic planning. It is at this level that discovery is initiated from the MITA SS-A process and plays a pivotal role in identifying the strengths and weakness over a broad spectrum of critical process areas within the Medicaid Enterprise. Individual processes are dissected and analyzed to determine: what is and what is not working, process steps, and interdependencies, duplication of system resources and business processes within the Enterprise, and organizational roles, responsibilities, and relationships. This establishes a current baseline of the Enterprise. By using the baseline information and the vision statement, strategies and specific future goals are formulated which describe future expected outcomes over strategic planning periods.

The DPW MITA EVS was conducted with the purpose of validating or revising the vision established in 2011 of the agency for transformations and improvements in the delivery of services to consumers and providers, in administrative services, and enabling technology. The visioning process benefited from previous efforts to envision the future and call for transformation and improvements in key business areas. These efforts included developing the DPW Enterprise State SMHP document and developing planning documents for the DPW Health Information Exchange (HIE). The Commonwealth will also be implementing a Health Insurance Exchange (HIX) utilizing the Federally Facilitated Marketplace (FFM) with the first enrollees starting October 1, 2013.

Cognosante has captured the following areas of focus from SMEs during sessions with DPW stakeholders and during As Is validation sessions:

1. Tracking Outcomes through Better Data.
2. Integration of Healthcare Services and Administration to Achieve Maximum Results.
3. Improvements to Quality of Health Care Measurement.

4. Business Process Modernization.

Business Area summaries and identified improvements are detailed in Section 3.

1.4 Executive Guiding Principles

As part of the Commonwealth's SMHP, a set of guiding principles was established for future system enhancements, program management, and process management. These guiding principles provide ongoing alignment with MITA goals and objectives. These guiding principles include:

The Department's MA HIT Vision is:

> *To improve the quality and coordination of care by connecting providers to patient information at the point of care through the meaningful use of [Electronic Health Records (EHRs)]*

The Department's goals include increased quality, awareness, and coordination. The implementation of EHRs is a significant challenge, bringing together clinical, operational, regulatory, and technical aspects of health care delivery but the Department is committed to addressing this challenge. Implementation and meaningful use of EHRs as well as other HIT projects, such as ePrescribing, reflects the Department's longstanding goal of improving patient care and outcomes and program effectiveness.

The Department will educate stakeholders about the role of HIT in improving the quality and coordination of health care services delivered to consumers and will actively encourage the adoption of HIT. The Department's goals include:

Increased Awareness – Education enables providers and consumers to understand the benefits of HIT adoption and the importance of exchanging health information for patients and caregivers.

Increased Quality – Better information to support clinical decisions by providers increases the probability of quality outcomes when combined with best practices and a common approach for consumers while reducing costs.

Increased Coordination – Eliminating duplicative services and administrative inefficiency results in better care coordination for consumers and often decreases the overall cost of care while improving positive outcomes.

System Redesign – Data capture and analysis provides opportunities to enhance and improve current quality initiatives for both providers and consumers and allows the Department to assess the effectiveness of existing programs and identify gaps in care.

The Executive Guiding Principles are used to prioritize the To Be goals within each of the MITA business processes and the MITA Roadmap. Details of the individual To Be goals by business process can be found in Section 3.

1.5 Pennsylvania Progress Since 2011 MITA SS-A

1.5.1 Completed Projects

The PME has successfully completed the following projects identified in the June 2011 Pennsylvania MITA SS-A Roadmap:

- **HIPAA: X12 5010 –** The Medicaid Enterprise and its business partners completed this significant effort over an 18 month period to upgrade electronic health care transactions from Version 4010/4010A1 to Version 5010 and National Council for Prescription Drug Programs (NCPDP) 5.1 to NCPDP D.0. Pennsylvania was compliant with these national standards on January 1, 2012.

- **National Correct Coding Initiative (NCCI) –** Pennsylvania implemented system enhancements to support the NCCI requirements through modifications to the MMIS editing and utilizing McKesson's ClaimCheck® software. This project was done in phases and was successfully completed on November 1, 2012.
- **PPACA: Operating Rules for Eligibility and Claim Status –** Pennsylvania adopted the Council for Affordable Quality Healthcare (CAQH)/Committee on Operating Rules for Information Exchange (CORE) operating rules to streamline eligibility, benefits, and claims data so providers receive more consistent data. Updates to the 270/271 transaction were completed in the Eligibility Verification System (EVS) effective January 1, 2013. Updates to the 276/277 transaction for the claim status inquiry and response were completed on June 30, 2013.
- **HITECH: Provider Incentive Payment (PIP) program/Meaningful Use –** Pennsylvania was the first member of a 13-state collaborative to implement the EHR Medical Assistance Provider Incentive Repository (MAPIR) incentive payment and meaningful use solution on June 6, 2011. As of May 2013, more than $207 million in EHR incentive payments have been made to eligible Pennsylvania providers through this nationally recognized and modular application.
- **Program Integrity/Fraud, Waste, and Abuse (FWA) –** Pennsylvania integrated the InvestiClaim FWA module into the MMIS to support pre-payment identification of potential fraud during claims and encounter processing in January 2013 and implemented FWA analytics in May 2013. Enhancements to the Enterprise Data Exchange (EDX) and systems for one-time instances and sanctions were made in April 2013 to support member FWA detection.
- **Expanded Use of Business Rules Engine –** Pennsylvania deployed the Corticon business rules engine to several applications in the Client Information System (CIS) and the Home and Community Services Information System (HCSIS).

1.5.2 Expansion of Managed Care and the Impact on Operations

Since the 2011 SS-A, Pennsylvania has eliminated the Primary Care Case Manager (PCCM) program known as ACCESS Plus in favor of statewide managed care. The HealthChoices Managed Care Organization (MCO) program has been expanded to cover the entire state. Over 80 percent of the Pennsylvania Medicaid population is now enrolled in managed care for care management. This shifted some of the administrative burden to the individual MCOs. The remainder of the population is managed by the fee-for-service (FFS), waiver, and LTC programs. The operations involved with these (non-MCO) programs were the primary focus of assessing the business processes. While managed care enrollment in the Commonwealth is approximately 81.5 percent[3], the remaining population (roughly 394,000) is still larger than the total Medicaid population in 19 other state Medicaid programs[4]. This large non-MCO population still requires a strong emphasis on monitoring and improving business processes efficiencies.

[3] Medicaid Managed Care Enrollment Report, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services (HHS), November 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

[4] Medicaid Managed Care Enrollment Report, Centers for Medicare and Medicaid Services, U.S. HHS, November 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

1.6 Summary of Key Findings

The DPW Medicaid Enterprise SMEs, with the assistance of the Cognosante project team, confirmed the As Is and determined the To Be MML of each business process. Maturity Level determination was made after assessing multiple capabilities as defined by MITA for each of the business processes.

1.6.1 Common Themes Emerging from the SS-A

There are a number of underlying themes that will provide both a foundation for decision-making and a challenge to the DPW Medicaid Enterprise's ability to meet and exceed the targeted MMLs identified by the SMEs. Section 3, MITA SS-A Business Assessment Results, and Section 5, MITA Gap Analysis provide further details on the business assessment themes.

- **Governance/Policy/Ownership** – Implementation of an Enterprise-wide governance structure to support the adoption of national standards and SOA. The governance team should be comprised of key stakeholders representing each of the MITA business areas. With the impacts of the 7C&S, HITECH, PPACA, Health Insurance Portability and Accountability Act (HIPAA), International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10), and MITA maturity improvements, a comprehensive plan to address ongoing system and data governance would benefit the Commonwealth.
- **Business Area Workflow** – The State should develop Concept of Operations (COO) models and implement an automated business process workflow tool to fully use staff resources for authorization, verification, validation, and conflict resolution.
- **Enterprise Transformation and Computing Modernization** – Transform the current system modules and implement all new modules using SOA to meet the requirements of federal and Commonwealth initiatives. This transformation will better satisfy future business needs of the Commonwealth by developing replaceable components with open interfaces. The systems should also take advantage of a separate business rules engine to reduce or eliminate the hard coding of certain system processes and make changes faster and less expensive.
- **Data Management and Reporting** – The State should comply with data standards as defined minimally by HIPAA and the health care industry when possible to ensure proper understanding and exchange of information. The improved data can then be used to produce reports and performance information to improve program evaluation.
- **Focus on Business Results**
  - **Increased Degree of Automation** – The Commonwealth has made progress to automate processes throughout the Enterprise. Each business area has a need for automation and collaboration to eliminate silos, increase modularization, and utilize standards for more efficient and effective workflow. Automating as many processes as possible will have a significant impact on the ability of Enterprise staff to better address external stakeholder needs and program improvement.
  - **Develop and Monitor Performance Standards** – Define, implement, collect, and report business process–related performance metrics that provide the necessary information to satisfy the MITA capability expectations and help programs meet performance objectives.
- **Stakeholder Satisfaction** – Utilize the data gathered on the MITA Business Process templates to identify and target areas to improve stakeholder satisfaction. Utilizing the feedback provided on the templates will allow the Commonwealth to directly link improvements to MITA capability increases. Implement automated tools to collect and analyze stakeholder input. The process of increasing stakeholder satisfaction includes dashboards for monitoring process improvements against stakeholder input, surveys, collecting metrics, and the use of predictive modeling to determine priorities of process improvements.

1.6.2 Summary of the Business Assessment Results

This section summarizes the results of the DPW Medicaid Enterprise SS-A for the business processes.

MITA provides the MITA Maturity Model (MMM) as the scale against which a business process is assessed. This scale consists of five Maturity Levels through which a process will evolve over time. The MITA framework defines the capabilities for each process at each of the five Maturity Levels. For a summary description of the MMM, see Figure 2: MML Summary in Section 1.3.2 Description of the MITA SS-A Process.

Table 1 and Table 2 below display the assessed As Is MITA Maturity of each business area, the desired To Be levels, and a bar graph showing them both combined. The tables display the business processes by the percentage of processes/functions per Maturity Level.

Color Legend: The proportion of the Business Area that is assessed at the indicated level (see percentage in parentheses).

1 – 25%		51 – 75%	
26 – 50%		76 – 100%	

Table 1: Summary of Business Assessment As Is Summary

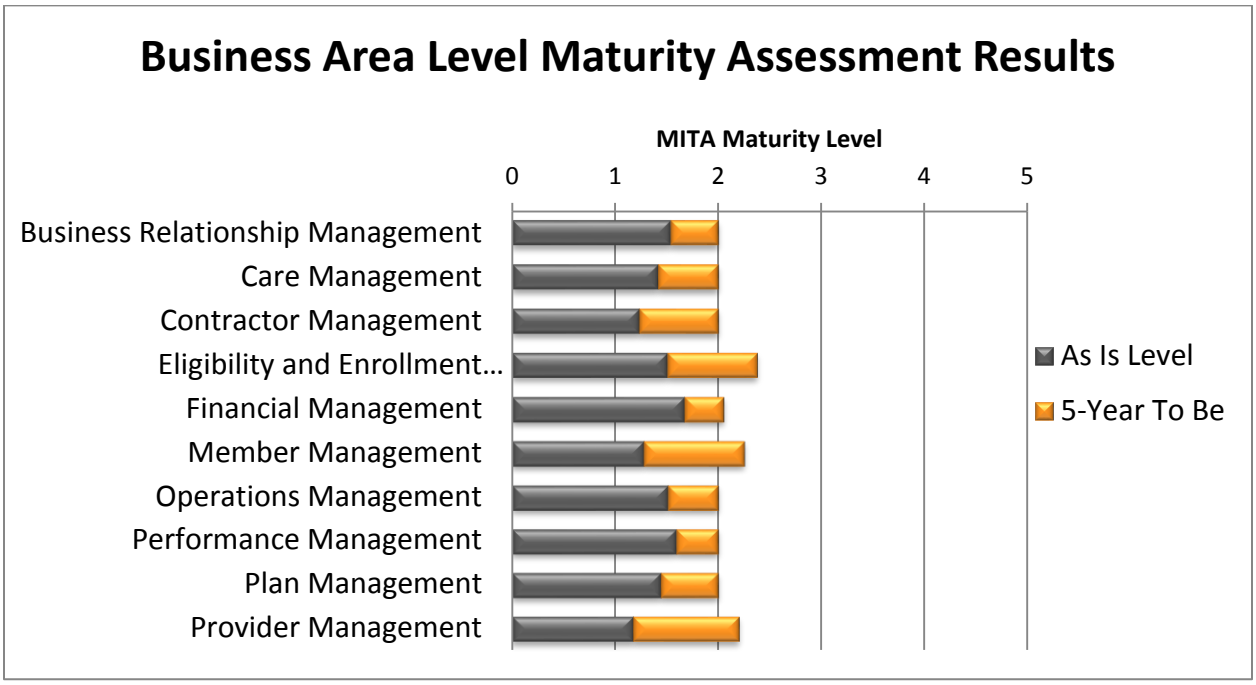
Business Area Name	*Maturity Level 1*	*Maturity Level 2*	*Maturity Level 3*	*Maturity Level 4*	*Maturity Level 5*
Member Management – 4 Business Processes	4 (100%)				
Financial Management – 19 Business Processes	17 (89%)	2 (11%)			
Operations Management – 11 Business Processes **Note:** MITA includes 9 business processes in this BA. There are also two PA-specific business processes added.	9 (82%)	2 (18%)			
Business Relationship Management – 4 Business Processes	4 (100%)				
Contractor Management – 9 Business Processes This BA as a whole is currently at Level 1	9 (100%)				
Provider Management – 5 Business Processes This BA as a whole is currently at Level 1	5 (100%)				
Performance Management – 5 Business Processes	4 (80%)	1 (20%)			
Care Management – 8 Business Processes	8 (100%)	0 (0%)			
Health Plan Management – 8 Business Processes	7 (88%)	1 (12%)			
Eligibility and Enrollment Management – 8 Business Processes	8 (100%)	0 (0%)			

Table 2: Summary of Business Assessment To Be Maturity Goals

To Be Assessment	*Maturity Level 1*	*Maturity Level 2*	*Maturity Level 3*	*Maturity Level 4*	*Maturity Level 5*
Member Management – 4 BPs					
Five Year To Be Goal		3 (75%)	1 (25%)		
Financial Management – 19 BPs					
Five Year To Be Goal		18 (95%)	1 (5%)		
Operations Management – 11 BPs					
Five Year To Be Goal		11 (100%)			
Business Relationship Management – 4 BPs					
Five Year To Be Goal		4 (100%)			
Contractor Management – 9 BPs					
Five Year To Be Goal		9 (100%)			
Provider Management – 5 BPs					
Five Year To Be Goal		4 (80%)	1 (20%)		
Performance Management – 5 BPs					
Five Year To Be Goal		5 (100%)			
Care Management – 8 BPs					
Five Year To Be Goal		8 (100%)			
Health Plan Management – 8 BPs					
Five Year To Be Goal		8 (100%)			
Eligibility and Enrollment Management – 8 BPs					
Five Year To Be Goal		5 (62%)	3 (38%)		

The following figure shows an average of all the capability levels in the individual business processes of each business area. The farther the bar is beyond Level 1, the more capabilities were assessed at Level 2. This graphic also shows the desired To Be level for each business area.

Figure 3: Business Area Level Maturity Assessment Results



1.6.3 Summary of Technical Assessment Results

The DPW Medicaid Enterprise SMEs, with the assistance of the Cognosante project team, confirmed and revised the technical and information Maturity Levels as part of the 2013 update. Technical maturity was assessed by the Cognosante technical analyst after conducting surveys and follow-up discussions with Technical SMEs. Maturity Level determination was made after assessing multiple capabilities as defined by MITA for each of the business areas, technical functions, and information capabilities.

Technical Assessment Themes are listed in no specific order.

1. Current System Governance is strong.
    a. The Fiscal Agent (FA) maintains a number of systems and networks throughout the PME. The BIS group has strong governance over several key systems across the enterprise. A key success moving forward will include integrating the governance and management of these areas.
    b. As the Commonwealth expands the Medicaid managed care portion of the population, systems and information capabilities will further focus on contract oversight, monitoring, and reporting.
2. Current System Integration.
    a. Open Interfaces: The 7C&S modularity standard requires that published Application Programming Interfaces (APIs) be used for module interfaces. This will need to be included in future systems integration planning. Until CMS publishes these standards, the Commonwealth is encouraged to use internal published standards.

b. The Commonwealth will begin planning for its MMIS transformation, upgrade, or replacement project over the next year. Current system integration will be a key consideration when replacing current MMIS capabilities.

c. Provider Reimbursement and Operations Management Information System (PROMISe™) integrates with many of the other systems, including the Enterprise Data Warehouse (EDW), CIS, HCSIS, and Master Provider Index (MPI).

d. Workflow management functionality meets most business needs in the majority of Medicaid systems.

e. Master Client Index (MCI) provides a central repository of client demographic information.

f. Many systems employ interoperability levels such as that provided by SOA and an Enterprise Service Bus (ESB).

3. Data Management.

   a. EDW performs many functions including developing entity relationship diagrams, the logical data model (LDM), keys, indexes, and partitioning strategies.

   b. EDW can be used as the catalyst for developing a Conceptual Data Model (CDM).

   c. Data mining is not utilized in the majority of Medicaid systems.

   d. Many systems have a standards-based data exchange mechanism in place.

4. Business Rules – While the Corticon business rules engine has been implemented for targeted uses, the expansion of the tool to eliminate the need for system coding in tightly coupled systems will be required to expand Corticon into other business process areas.

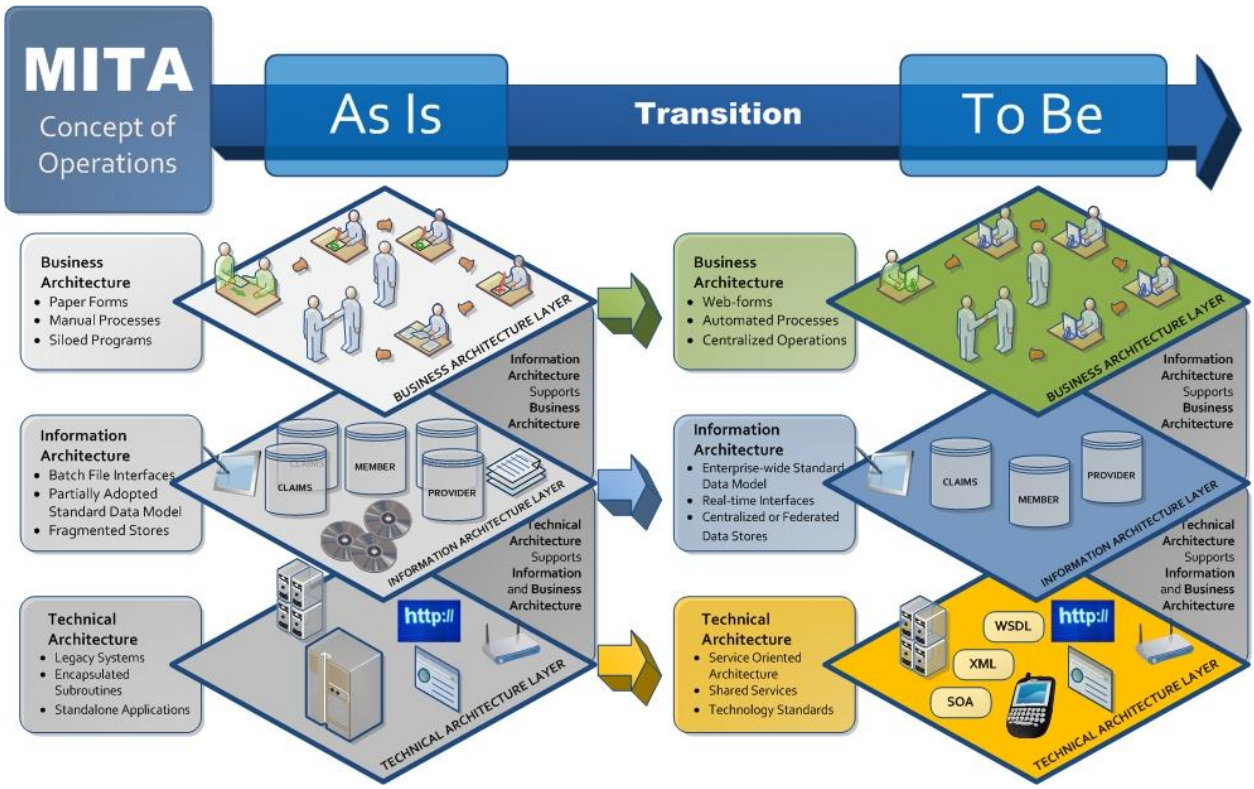
1.7 Concept of Operations

CMS recently reaffirmed its guidance to states to focus on a COO when assessing current capabilities and outlining future goals. In its April 2011 MITS, CMS states:

> "States should develop a concept of operations and business work flows for the different business functions of the state to advance the alignment of the state's capability maturity with the MMM. These COO and business workflows should align to any provided by CMS in support of Medicaid and Exchange business operations and requirements. States should work to streamline and standardize these operational approaches and business work flows to minimize customization demands on technology solutions and optimize business outcomes."

The illustration below represents a high-level view of COO planning. It includes the three architectures of MITA and how capability improvements can be made in each area to reach increasing levels of MITA maturity as shown in Figure 4.

Figure 4: MITA COO



The SS-A and the plan to achieve the desired To Be Maturity Levels is developed by the Enterprise and remains a living document. The MITA framework provides the roadmap guidelines, but DPW must prioritize and specify its own roadmap. Throughout the course of the journey priorities may change, new federal and state laws will demand more immediate attention, and technology itself will continue to evolve. The goal of MITA is to establish a baseline from which to plan and support revision of the plan in order to move the DPW Medicaid Enterprise forward.

2.0 DPW MEDICAID ENTERPRISE SS-A OVERVIEW

2.1 Project Scope and Approach

The core of the DPW MITA 3.0 SS-A is comprised of the following sections:

- MITA Business Assessment Results
- MITA Technical Assessment Results
- MITA Gap Analysis
- MITA To Be Roadmap

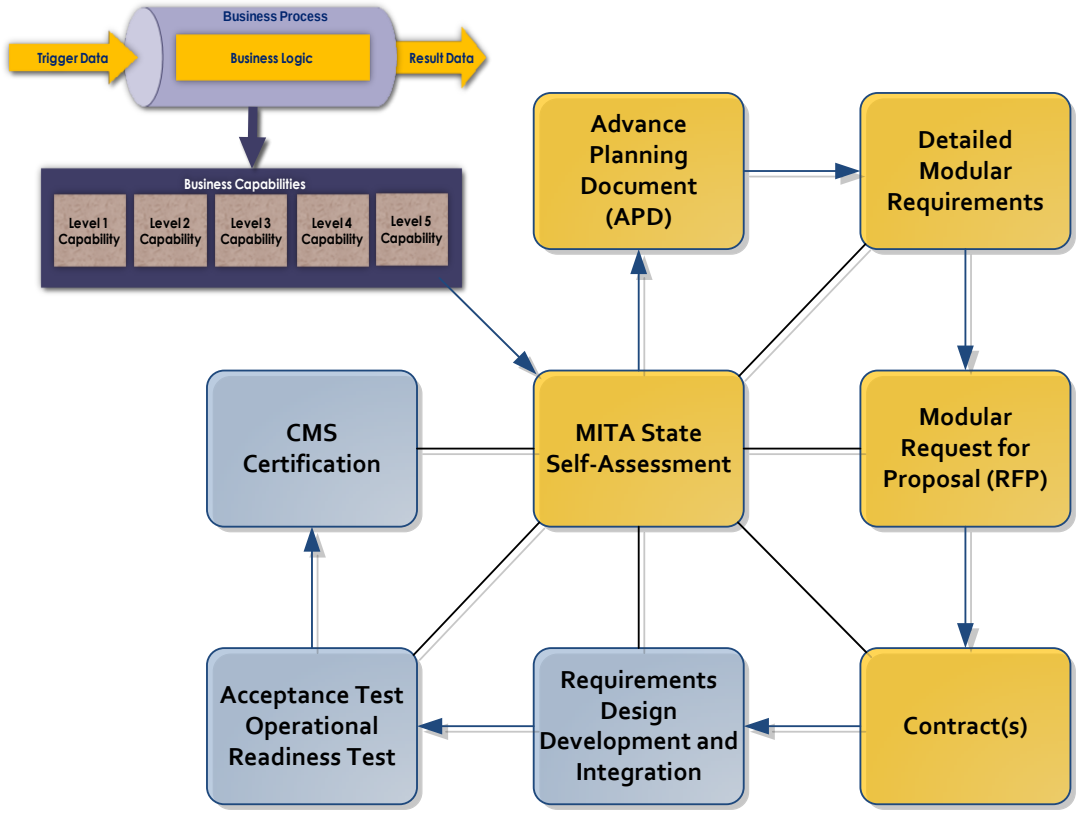
2.1.1 Identifying the Outputs from the MITA SS-A

The MITA SS-A is a tool that figures prominently into the project and procurement life cycle. It is at the heart of many, if not all, project planning processes within the scope of the Medicaid Enterprise. The core goal of the SS-A is to identify and include for each business process a detailed description of its Maturity Level, capabilities, and qualities, along with current and potential measures as they relate to meeting State program management needs. This information is an input to other strategic project planning areas and deliverables such as the Implementation Advance Planning Document (IAPD), Requirements Planning, Unified Modeling Language (UML), Business Process Modeling (BPM), Cost Benefit Analysis (CBA), and the Request for Proposal (RFP) document. For this reason, it is important to identify the primary outputs from the MITA SS-A process:

- First, a detailed description of the current As Is state of each business process, its associated capabilities, qualities (what is going right/wrong), and the organizational units responsible for implementing them.
- Second, a MML assessed for each of the current As Is business processes.
- Third, a description of the DPW current Medicaid IT systems architecture and environment. This description identifies the technology baseline that will be taken into consideration when evaluating which business processes to improve and when the accompanying technological changes will be required.
- Fourth and last, each business process is evaluated for potential process improvements. When aligned with the prioritized To Be goals and objectives of Executive Management, the future To Be level of maturity for each business process is established.

The MITA process workflow, as described above, is shown in the figure below.

Figure 5: MITA Information Flow



As stated earlier, the MITA SS-A is a living document to be used as a strategic tool throughout the life of the Medicaid program. The SS-A is to provide the State a roadmap to future enhancements and will be re-evaluated as business processes progress through the MMLs. Key uses of this MITA SS-A are identified below.

MITA Inputs to the Transition and Implementation Plan (MITA Roadmap)

Information collected during the MITA SS-A sessions is leveraged to develop a strategic plan known as the MITA Roadmap. While the MITA SS-A documents the DPW business processes in their current state (As Is) and potential future state (To Be), the gap analysis makes a clear distinction between existing and future system capabilities. It also defines the enhanced functionality necessary to arrive at the To Be state. The gap analysis identifies the intermediary steps in aligning business processes and system architectures by defining functional specifications and requirements that cumulatively will achieve the next level of maturity in the capabilities matrix when addressed. The following are other factors used to develop the SS-A and the MITA Roadmap:

- Projects envisioned as advancing Commonwealth goals and objectives and increasing MMLs based on a set of assumptions (opportunities and constraints). These projects were presented during EVS early in the project.
- Strategic plan of projects and activities required to achieve the projected To Be state – including both Business and IT Architecture.
- Recommended governance and structure to support future model development throughout the project life cycle.

MITA Inputs to Requirements Gathering

The MITA SS-A is a foundational document used to draft future solicitation documents. In addition to the MITA SS-A document, future requirements documents include the CMS Medicaid Enterprise Certification Toolkit (MECT), IAPDs, previous DPW MMIS RFPs, current documentation (i.e., manuals, procedures), current MMIS change requests, State technical standards, and recent MMIS RFPs from other states.

Improvements initially identified in the MITA SS-A as potential To Be goals for the future will be leveraged into specifications and requirements to be further validated and developed during Joint Application Development (JAD) sessions. Future MITA requirements and system enhancements will be mapped by business area to establish an audit trail for maturity gains associated with their respective business maturity matrix.

MITA Inputs to the IAPD

States requesting enhanced FFP for new and ongoing projects must have prior approval through a series of Advance Planning Documents (APDs) before beginning system design and development. In fulfilling this CMS requirement, states are also required to provide the results of their MITA SS-A in a summary attachment "Appendix E" to the Implementation Advance Planning Document Update (IAPDU). The Appendix provides the details associated with specific business process maturity gains, which will be accomplished by implementation of the project by the state including As Is MMLs, target To Be MMLs, and State-specific business processes captured during the assessment to CMS.

The primary component of the IAPD is an explanation of anticipated costs associated with a system Design, Development, and Implementation (DDI) and MMIS ongoing operations. The DPW MITA SS-A and gap analysis provide input for determining viable system options for implementation in DPW. From these options, a CBA is developed and presented to CMS staff.

The MITA Assessment and associated MITA Roadmap, in conjunction with future IAPDs, will establish future funding and audit trails as part of a governance structure utilizing a System Development Life cycle Concept (SDLC). The Summary Business Capability Matrix (BCM) submitted to CMS identifies potential system enhancements and maturity gains for specific processes and process areas over the project life cycle.

In April 2011, CMS issued guidance on Enhanced Funding Requirement: 7C&S [5]. The purpose of this guidance is to:

- Ensure that enhanced FFP funding is approved only when Medicaid infrastructure and information systems projects meet statutory and regulatory requirements to support efficient and effective operations of the program
- Assist states as they design, develop, implement, and operate technology and systems projects in support of the Medicaid program
- Allow states to meet the conditions and standards for enhanced federal match for Medicaid technology investments

The guidance outlines 7C&S that CMS is looking for as states develop their APDs:

1. **Modularity Standard** – Requires the use of a modular, flexible approach to systems development, including the use of open interfaces and exposed APIs; the separation of business rules from the core programming; and the availability of business rules in both human and machine-readable formats.

[5] CMS, Medicaid IT Supplement (MITS-11-01-v1.0), April 2011

2. **MITA Condition** – Requires states to align to and advance increasingly in MITA maturity for business, architecture, and data. CMS expects the states to complete and continue to make measurable progress in implementing their MITA Roadmaps.
3. **Industry Standards Condition** – Requires states to align with and incorporate industry standards, specifically standards and protocols adopted in the Affordable Care Act (ACA), HIPAA security, privacy, and transactions standards, and the Rehabilitation Act accessibility standards or standards that provide greater accessibility for individuals with disabilities, and compliance with federal civil rights laws.
4. **Leverage Condition** – Promotion and implementation of sharing, leverage, and reuse of Medicaid technologies and systems within and among states.
5. **Business Results Condition** – Systems should support accurate and timely processing claims (including claims of eligibility), and effective communications with providers, beneficiaries, and the public.
6. **Reporting Condition** – Solutions should produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.
7. **Interoperability Condition** – Systems must ensure seamless coordination and integration with the Exchange (whether run by the state or federal government), and allow interoperability with HIEs, public health agencies, human services programs, and community organizations providing outreach assistance services.

To see an example of how these seven conditions are used, refer to the Enhanced Funding Requirements: Expedited APD Checklist specifically for Medicaid Eligibility and Enrollment and Information Systems[6] (E&E-APD).

2.2 Business Assessment Process

A MITA SS-A hinges on determining the executive vision for the future, establishing the impacted internal Enterprise stakeholders, capturing the current Maturity Level of business processes within the Enterprise, and envisioning the capabilities of an MMIS as it is enhanced over time. While MITA establishes a framework, that framework only serves to initiate the discussion.

Cognosante worked with the State project manager to establish the project management processes and procedures to support the MITA SS-A. These included the support of key management and SMEs throughout the State's Medicaid business and technology enterprise. To begin the project, Cognosante conducted the MITA SS-A Project Kickoff meeting to present to the Project Steering Committee and Executive Senior Staff an overview of the MITA concept and project governance goals and objectives for implementing project processes.

Surveys were again administered containing strategic questions to determine what business process inputs had changed (if any) from the last MITA SS-A conducted in 2011. This information along with information gathered from the previous MITA SS-A templates from 2011 were consolidated to facilitate a new set of MITA SS-A Business Process Assessment sessions. Through a facilitated group review process, the SMEs were questioned about their current business processes and encouraged to elaborate on constraints, opportunities, current issues, and wishes for improved business functionality. This

[6] CMS, Medicaid IT Supplement (MITS-11-02-v1.0), April 2011

information was added to the templates and the templates were submitted to the staff for review and feedback.

Based on the information gathered in the business process sessions, MMLs were assessed for both As Is and To Be and in consideration of the 5-year MITA maturity milestone dates previously discussed. Maturity assessments for each business process can be found in a table under each of the Business Areas in Section 3, along with an overall discussion of the As Is and To Be objectives for the Business Area as a whole.

Once the SS-A is complete, the process culminates in the preparation of MITA documentation to support future activities.

2.3 Technical Assessment Process

In order to capture relevant As Is information, technical SMEs were identified and surveys created with questions generally aligned to systems supporting the DPW Medicaid Enterprise Technical Assessment. The questions are based on technical functions discussed in the MITA Framework 3.0 Part III – Technical Assessment and other systems. The survey was sent out to SMEs, State technical staff, and MMIS FA staff. The respondents completed the survey with pertinent system specific information.

SMEs met with Cognosante to validate the enumerated systems, interfaces, and supporting applications between the outer edge/interfaces of the DPW Medicaid Enterprise. Cognosante prepared an additional set of questions related to the state architectural infrastructure focusing on any gaps that were identified through the first round of discovery. From the information gathered in that meeting, differences in interpreting systems, interfaces, applications, and any other technical-related information were resolved. The results were analyzed by Cognosante and a synopsis of the As Is information was written for each technical area and function. An assessment of the technical maturity was performed for each technical function based on the Technical Capability Matrix (TCM) guidelines outlined in MITA Framework 3.0 (where applicable).

3.0 MITA SS-A Business Assessment Results

This section presents the results of the MITA SS-A Business Assessment. Section 3.1 displays the output from the first exercise in which the Cognosante team and Commonwealth SMEs engaged, aligning the MITA Business Assessment with the PME. Section 3.2 is divided into the 10 MITA Business Areas; it presents assessment results in more detail than presented in the Executive Summary.

3.1 MITA to Pennsylvania Business Process Crosswalk

One of the first steps in a MITA SS-A is to map the MITA Business Assessment and its individual business processes to the PME. The following table presents the results of the mapping exercise. Pennsylvania business processes in the left-hand column are mapped to the MITA business processes in the two right-hand columns. The business process number is a unique identifier Cognosante uses to simplify tracking the data that is collected about the business process.

Table Legend:

Business Area Name
Business Category Name
New Name/process in 3.0
Pennsylvania Specific
Notes

Table 3: MITA 2.01 to 3.0 Crosswalk

Pennsylvania Business Process	MITA 2.01	MITA 3.0
	Business Relationship Management (BR)	**Business Relationship Management (BR)**
		Standards Management
Establish Business Relationship	BR01 Establish Business Relationship	BR01 Establish Business Relationship
Manage Business Relationship	BR02 Manage Business Relationship Communications	BR02 Manage Business Relationship Communications
Terminate Business Relationship	BR03 Manage Business Relationship	BR03 Manage Business Relationship Information
Manage Business Relationship Communications	BR04 Terminate Business Relationship	BR04 Terminate Business Relationship
	Contractor Management (CO)	**Contractor Management (CO)**
	Contractor Information Management	*Contractor Information Management*
Manage Contractor Information	CO05 Manage Contractor Information	CO01 Manage Contractor Information
Inquire Contractor Information	CO09 Inquire Contractor Information	CO04 Inquire Contractor Information
	Contractor Support	*Contractor Support*
Manage Contractor Communication	CO06 Manage Contractor Communication	CO02 Manage Contractor Communication
Perform Contractor Outreach	CO07 Perform Contractor Outreach	CO03 Perform Contractor Outreach
Support Contractor Grievance and Appeal	CO08 Support Contractor Grievance and Appeal	CO09 Manage Contractor Grievance and Appeal
	Contracting	*Contract Management*
Produce Administrative or Health Services RFP	CO01 Produce Request for Proposal	CO05 Produce Request for Proposal
Award Administrative or Health Services Contract	CO02 Award Administrative and Health Services Contract	CO06 Award Contract
Manage Administrative or Health Services Contract	CO03 Manage Administrative and Health Services Contract	CO07 Manage Contract
Close-Out Administrative or Health	CO04 Close Out Administrative and	CO08 Close Out Contract

Pennsylvania Business Process	MITA 2.01	MITA 3.0
Services Contract	Health Services Contract	
	Member Management (ME)	**Member Management (ME)**
	Member Information Management (1 of 2)	*Member Information Management*
Manage Member Information	ME07 Manage Member Information	ME01 Manage Member Information
	Prospective and Current Member Support	*Member Support*
Manage Applicant and Member Communication	ME05 Manage Applicant and Member Communication	ME02 Manage Applicant and Member Communication
Manage Member Grievance and Appeal	ME06 Manage Member Grievance and Appeal	ME08 Manage Member Grievance and Appeal
Perform Population and Member Outreach	ME08 Perform Population and Member Outreach	ME03 Perform Population and Member Outreach
		Eligibility and Enrollment Management (EE)
	Eligibility Determination	*Member Enrollment*
Determine Eligibility	ME01 Determine Eligibility	EE01Determine Member Eligibility
	Enrollment	
Enroll Member	ME02 Enroll Member	EE02 Enroll Member
Disenroll Member	ME03 Disenroll Member	EE03 Disenroll Member
	Member Information Management (2 of 2)	
Inquire Member Eligibility	ME04 Inquire Member Eligibility	EE04 Inquire Member Eligibility
	Provider Management (PM)	
	Provider Enrollment	*Provider Enrollment*
Enroll Provider	PM04 Enroll Provider	EE05 Determine Provider Eligibility
		EE06 Enroll Provider
Disenroll Provider	PM06 Disenroll Provider	EE07 Disenroll Provider
	Provider Information Management	
Inquire Provider Information	PM03 Inquire Provider Information	EE08 Inquire Provider Information
		Provider Management (PM)
		Provider Information Management
Manage Provider Information	PM06 Manage Provider Information	PM01 Manage Provider Information
		PM08 Terminate Provider *(a combination of PI Establish and Manage Case and EE07)*
	Provider Support	*Provider Support*
Manage Provider Communication	PM04 Manage Provider Communication	PM02 Manage Provider Communication
Manage Provider Grievance and Appeal	PM05 Manage Provider Grievance and Appeal	PM07 Manage Provider Grievance and Appeal
Perform Provider Outreach	PM07 Perform Provider Outreach	PM03 Perform Provider Outreach
	Care Management	**Care Management (CM)**
		Case Management
Establish Case	CM01 Establish Case	CM01 Establish Case *(description points to treatment plans developed in this process)*
Manage Case	CM02 Manage Case	CM02 Manage Case Information *(treatment plans developed and monitored here)*
Manage Medicaid Population Health	CM03 Manage Medicaid Population Health	CM03 Manage Population Health Outreach
Manage Registry	CM04 Manage Registry	CM04 Manage Registry
		CM05 Perform Screening and

Pennsylvania Business Process	MITA 2.01	MITA 3.0
		Assessment *(description implies this activity is only applicable to enrollment)*
		CM06 Manage Treatment Plan and Outcomes *(description points to treatment plans reviewed and modified, not (necessarily) case related)*
	Operations Management	
	Service Authorization	*Authorization Determination*
Not a Pennsylvania Process	OM01 Authorize Referral	CM07 Authorize Referral
Authorize Service	OM02 Authorize Service	CM08 Authorize Service
Authorize Treatment Plan	OM03 Authorize Treatment Plan	CM09 Authorize Treatment Plan
		Operations Management (OM)
	Payment Management - Claim/Encounter Adjudication (1-3 of 5)	*Claims Adjudication*
Edit Claim/Encounter	OM06 Edit Claim/Encounter	OM07 Process Claim
Audit Claim/Encounter	OM07 Audit Claim/Encounter	*Included in OM07*
Price Claim/Value Encounter	OM08 Price Claim/Value Encounter	*Included in OM07*
	Payment Management – Payment and Reporting (1 of 6)	
Prepare COB	OM11 Prepare COB	*Included in OM07*
	Payment Management - Claim/Encounter Adjudication (4-5 of 5)	
		OM29 Process Encounter
Apply Attachment	OM04 Apply Attachment	OM04 Submit Electronic Attachment
Apply Mass Adjustment	OM05 Apply Mass Adjustment	OM05 Apply Mass Adjustment
	Payment Management – Member Payment Management (1 of 2)	
Calculate Spend-Down Amount	OM20 Calculate Spend-Down Amount	OM20 Calculate Spend-Down Amount
	Payment Management – Payment and Reporting 2-3 of 6)	*Payment and Reporting*
Prepare Remittance Advice/Encounter Report	OM09 Prepare Remittance Advice/Encounter Report	OM14 Generate Remittance Advice
		OM27 Prepare Provider Payment
Prepare Home and Community Based Services Payment	OM13 Prepare HCBS Payment	*Included in OM27*
	Payment Management – Payment Information Management	
Inquire Payment Status	OM18 Inquire Payment Status	OM18 Inquire Payment Status
Manage Payment Information	OM19 Manage Payment Information	*See FM06, FM13, and FM17*
		OM28 Manage Data *(manage federal data delivery)*
		Financial Management (FM)
	Cost Recoveries	*Accounts Receivable Management*
Manage Recoupment	OM24 Manage Recoupment	FM01 Manage Provider Recoupment
Manage TPL Recovery	OM26 Manage TPL Recovery	FM02 Manage TPL Recovery
Manage Estate Recovery	OM23 Manage Estate Recovery	FM03 Manage Estate Recovery
Manage Drug Rebate	OM22 Manage Drug Rebate	FM04 Manage Drug Rebate
Manage Cost Settlement	OM25 Manage Cost Settlement	FM05 Manage Cost Settlement
		FM06 Manage Accounts Receivable Information

Pennsylvania Business Process	MITA 2.01	MITA 3.0
		(was p*art of OM19 Manage Payment Information)*
Perform Accounting Functions	PG 15 Perform Accounting Functions	FM07 Manage Accounts Receivable Collection/Refunds
Pennsylvania Specific	OM29 Manage Payment of Non-Emergency Transportation	
	Payment Management – Member Payment Management (2 of 2)	
Prepare Member Premium Invoice	OM21 Prepare Member Premium Invoice	FM08 Prepare Member Premium Invoice *(Member cost sharing through the collection of premiums for medical coverage provided under Medicaid and Children's Health Insurance Program (CHIP)*
		Accounts Payable Management
		FM09 Manage Contractor Payment *(invoice payment* - was p*art of OM19 Manage Payment Information)*
	Payment Management – Capitation and Premium Payment	
Prepare Medicare Premium Payment	OM17 Prepare Medicare Premium Payment	FM10 Manage Member Premium Payment
Prepare Health Insurance premium Payment	OM16 Prepare Health Insurance Premium Payment	*Included in FM10*
Prepare Capitation Premium Payment	OM15 Prepare Capitation Premium Payment	FM11 Manage Capitation Payment
		FM12 Manage Incentive Payments
		FM13 Manage Accounts Payable Information (was p*art of OM19 Manage Payment Information)*
		FM14 Manage Accounts Payable Disbursement (was *part of PG15 Perform Accounting Functions and OM13 and OM12)*
	Payment Management – Payment and Reporting (4-5 of 6)	
Prepare Provider EFT/Check	OM10 Prepare Provider EFT/Check	*Included in FM14*
Prepare Premium EFT/check	OM14 Prepare Premium EFT/Check	*Included in FM14*
	Program Management	
	Accounting	
Perform Accounting Functions	PG15 Perform Accounting Functions	*See FM07, FM09, FM14*
Manage 1099s	PG11 Manage 1099s	FM15 Manage 1099s
	Budget	*Fiscal Management*
Formulate Budget	PG07 Formulate Budget (*v2.02)*	FM16 Formulate Budget
		FM17 Manage Budget Information (was p*art of OM19 Manage Payment Information)*
		FM18 Manage Fund
Manage FMAP	PG10 Manage F-MAP	*Included in FM18*
Manage FFP for MMIS	PG08 Manage FFP for MMIS	*Included in FM18*
Manage FFP for Services	PG19 Manage FFP for Services	*Included in FM18*
Draw and Report FFP	PG18 Draw and Report FFP	*Included in FM18*

Pennsylvania Business Process	MITA 2.01	MITA 3.0
Manage State Funds	PG10 Manage State Funds	*Included in FM18*
	Program Information (1 and 2 of 3)	
Generate Financial and Program Analysis Report	PG12 Generate Financial and Program Analysis Report	FM19 Generate Financial Reports
		Plan Management (PL)
	Program Administration	*Plan Administration*
Develop Agency Goals and Objectives	PG04 Develop Agency Goals and Objectives	PL01 Develop Agency Goals and Objectives
Develop and Maintain Program Policy	PG05 Develop and Maintain Program Policy	PL02 Maintain Program Policy
Maintain State Plan	PG06 Maintain State Plan	PL03 Maintain State Plan
	Benefit Administration	*Health Benefits Administration*
Develop and Maintain Benefit Package	PG02 Develop and Maintain Benefit Package	PL06 Manage Health Benefit Information
Maintain Benefits/Reference Information	PG13 Manage Benefit-Reference Information	PL07 Manage Reference Information
Designate Approved Services and Drug Formulary	PG01 Designate Approved Service and Drug Formulary	*Included in previous Business Process*
Manage Rate Setting	PG03 Manage Rate Setting	PL08 Manage Rate Setting
	Program Information (3 of 3)	*Health Plan Administration*
Manage Program Information	PG14 Manage Program Information	PL04 Manage Health Plan Information
	Program Quality Development	
Develop and Manage Performance Measures and Reporting	PG16 Develop and Manage Performance Measures and Reporting	PL05 Manage Performance Measures
Monitor Performance and Business Activity	PG17 Monitor Performance and Business Activity	*Included in PL05*
	Program Integrity Management	**Performance Management (PE)**
		Compliance Management
Identify Candidate Case	PI01 Identify Candidate Case	PE01 Identify Utilization Anomalies
		PE02 Establish Compliance Incident
		PE03 Manage Compliance Incident Information
Manage Case	PI02 Manage Case	PE04 Determine Adverse Action Incident
	Operations Management - *Payment Management – Payment and Reporting (6 of 6)*	
Prepare EOB	OM12 Prepare EOB	PE05 Prepare REOMB
Pennsylvania Specific	OM27 Manage Drug Rebate Dispute Resolution	OM30 Manage Drug Rebate Dispute Resolution
Pennsylvania Specific	OM28 Manage Co-Pay Rebate	*Manage Copay Rebate (noted in FM12 – Manage Incentive Payments as discontinued)*
Pennsylvania Specific	OM29 Manage Payment of Non-Emergency Transportation	OM31 Manage Payment of Non-Emergency Transportation

3.2 Pennsylvania Business Assessment Results by MITA Business Area

The remainder of this section contains a description for each Business Area describing the following:

- As Is Business Capabilities Assessment shows the result of the review of each of the MITA business processes
- To Be Business Capabilities Assessments show the desired capabilities
- Five-Year Maturity Description – Summarizes the improvements that the personnel want to achieve within 5-years

Appendix B offers further detail on the MITA Maturity assessment for each business process.

3.3 Member Management

3.3.1 Overview

The Member Management business area is a collection of business processes involved in communications between the Pennsylvania Medicaid Agency (PMA) 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.

3.3.2 Member Management As Is Summary

The Commonwealth of Pennsylvania Access to Social Services (COMPASS) system is an integrated, web-based, multilingual, self-service tool. The Pennsylvania COMPASS solution provides users (both citizens and community partners) with greater flexibility in receiving and managing social service benefits in the Commonwealth. Recipients can apply for and renew benefits for up to 13 programs via a single point of entry. Recipients can report changes to their information, determine if they are potentially eligible for various health, financial and nutrition programs, and check the status of their benefits.

Application data from COMPASS is passed to the CIS, a Common Business Oriented Language (COBOL)–based mainframe driven suite of systems that serves as the backbone for Pennsylvania and supports activities ranging from claims processing to benefits distribution. CISs two largest components are eligibility determination and case management.

The MCI serves as a central repository for consumer demographic data. MCI allows Pennsylvania to uniquely identify consumers who are participating in programs as well as provides opportunities to better serve consumers and improve program and information reporting.

Application data entry can be untimely and inaccurate due to county assistance offices (CAOs) workload and turnover. The MMIS accesses CIS databases in real-time to obtain data to support claims processing activities and exchanges batch files between the systems. While the receipt of enrollment and disenrollment data is fully automated, the processing of the data is siloed. Manual intervention is required to correct the data inconsistencies, resulting in delays in members' access to care.

The online and batch enrollment processes support approximately 2.7 million needy Pennsylvanians. Daily and monthly electronic files are sent to the MCOs, the enrollment broker, Medical Assistance Transportation Program (MATP) contractor, radiology vendor, actuarial contractor, and PROMISe™ (MMIS). The systems (e.g., CIS and MMIS) cannot accommodate all of Pennsylvania's business rules, exceptions to the rules, and unique situations. Frequent manual intervention is needed to manage member information and perform communication activities.

Numerous programs and business units within the Medicaid Enterprise perform or have a role in managing Member Management. These include, but are not limited to:

- DOH
- DMVA
- DPW
  - OA
    - BIS
  - Office of Communications
  - OCDEL
  - ODP
  - OIM
    - CAOs
  - OLTL
  - OMAP
    - BDCM
    - BFFSP
    - BMCO
    - BPAP
  - OMHSAS
- Governor's Office of Administration
  - OIT
- PDA
- PDE
- PID
  - CHIP
- SSA

Other:

- Philadelphia HHS – Division Department of Health Human Services (District 51Y)
- Medicaid Providers
- Medicaid Managed Care Enrollment Broker

Review of the Pennsylvania Member Management business area indicates the As Is Capability Maturity Level is currently determined to be at a Level 1. The primary factors affecting maturity ratings across the Member Management Business Area include the following:

- A mixture of automated and manual business processes
- Manual intervention is required due to contractual and unique rules and processes that often reduce the effectiveness of the automated processes
- Data validation and verification is primarily a manual process
- Ongoing, manual data manipulation during various steps of the processes affects the cost-effectiveness of this process
- Stakeholder satisfaction is not consistently tracked and measured in all business processes

3.3.3 Member Management To Be Summary

As established during the Commonwealth's EVS, and as a result of the upcoming implementation of the ACA, this business area is considered a high priority. This business area will advance in Maturity Levels as system changes and enhancements relevant to the ACA are implemented.

The Commonwealth will focus on ACA compliance, using a model and approach that complies with 7C&S. The Commonwealth will retain integration across federal and state-funded benefit programs by using flexible architecture and leveraging the Corticon rules engine (which is part of COMPASS). This approach helps to ensure the Commonwealth's primary goals are met, including improving eligibility processing capabilities and enhancing the Medicaid Enterprise in a controlled, deliberate manner that mitigates impacts to recipients, the Commonwealth's business operations, and program operations.

The Pennsylvania goals for Member Management, as determined during the Executive Vision Session are:

- Enhanced use of the MCI
- Provide secure, web-based assessment tool for OLTL functions
- Provide online, web-interface data submission from assessment tools to enable real-time eligibility determination and enrollment for all human services programs in the Commonwealth
- Provide comprehensive online member and case management
- Provide program integration through collaboration with other entities
- Ensure that information is available to the client via a Personal Health Record
- Ensure that client eligibility and enrollment data is available across all programs
- Eliminate duplicate information and processes and implement a one-stop shop system across all departments
- Support reuse and (authorized) sharing of information

Additional primary functional capability improvements across the Member Management area include the following:

Governance/Policy

- Top-to-bottom infrastructure review to determine what improvements need to be made
- Management of policy, security, access, statute, and regulation will be paramount during system development
- Leverage existing policy and legislature to take advantage of available data resources (PID, carrier files, etc.) across departments, states, commercial, and public resources
- Promote self-service outreach as much as possible, using a dynamic information structure

Workflow

- Business process workflow will need to be addressed as a project to ensure all eligibility intake processes can be met by the system. The workflow functionality must support flexibility while enforcing business rules across various programs.

System Functionality

- Automated triggers and notifications
- Ensure self-service functionality to members, which include information about that program
- Detailed status notifications for the application process
- Integrate text message and other functionality to enhance communication with the member
- Ability for members to update data that would then be pending for approval
- Self-service data modification functionality must be role based
- Ability for the member to identify users to grant full access to the health record, program information, and other account data
- Member portal must support role-based security to determine access
- Ability to find and present information to members. This functionality must include the ability for the user to enter a Recipient Identification Number (RID) and the portal will present common

information including current benefit package, limitations, co-pays, and other information. The HIPAA 5010 eligibility transactions are a potential vehicle for this communication, but other options could be explored.

- Functionality to support stakeholder satisfaction. This will allow members to provide feedback, suggestions, questions, and other interactions.
- Implement a Customer Relationship Management (CRM) system to support all member interactions that support management and resolution of grievances and appeals. This CRM will integrate with the MCOs.

Data Management

- The data model and process flow must capture the data necessary for process and fiscal analysis. This must support reporting for program management and other initiatives.
- Integrate data in a process where a common data model can be easily adapted. These would include integrating CIS, PROMISe™ member table, HCSIS, and other systems.
- As part of data model developments, other peripheral systems will require special conditions when integrating the data and ultimately the system. These may include Social Assistance Management System (SAMS), CaseNet, and external registries from DOH.
- Maintain a library of grievance and appeals resolution for use in making decisions

The graph provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 6: Member Management Business Area

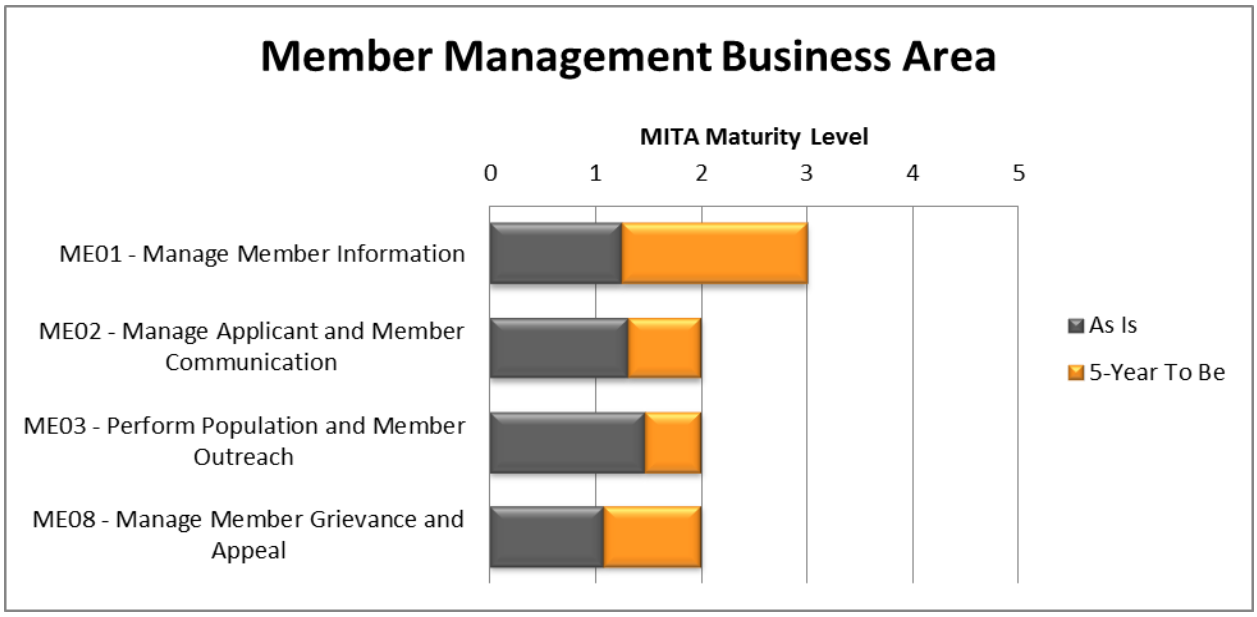


Table 4: Member Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
ME01 Manage Member Information	**1**	1. Managed care processes are highly automated but due to the large PMA population and certain "unique" contractual procedures and rules, there is a considerable amount of manual intervention required to correct errors or update managed care information in both CIS and PROMISe™. 2. Most online and batch processes that update or extract information from CIS work fairly well. PROMISe™ also processes capitation payments and updates various payment and reference files. 3. Recipient information is updated primarily by the caseworkers in OIM. Other data feeds into CIS include but are not limited to SSA, plans, enrollment broker, Third-Party Liability (TPL), CMS, and other entities have an effect on the timeliness and quality of the data. Manual updates occur for the managed care information in CIS. Most updates are automated and timely; however, manual updates are required. Data extractions are fully automated. 4. The quality of the data is dependent upon the source of the change (i.e., caseworkers/staff, SSA). 5. Pennsylvania's CIS is the member data store where Medical Assistance (MA) eligibility and enrollment information is collected and stored. PROMISe™ is the repository for all health benefits and claims information and is the system that providers and pharmacies use for billing and eligibility verification. 6. The process is accurate to the degree of automation and	**3**	1. At this level, the Manage Member Information business process meets the needs of programs beyond FFS and continues to be validated by external measures. Manual intervention decreases from that at Level 1. 2. Timelier member updates and data extractions result in availability on the day of the update. Notification to interested users and processes is immediate (as soon as update occurs). 3. The process is more streamlined among various programs. Updates are automated; paper or hand-delivered files are the exception. Updates are automated with date stamp and audit trail. Increasing automation leads to greater productivity and cost effectiveness than at Level 1. Data updates are standardized; requested and scheduled data extraction is increasingly automated. 4. Automated updates are made to individual files and databases. Applied edits reduce inaccuracy. 5. Databases may be relational. Rule-based validation and data reconciliation is more consistent and improves integrity of data repository. 6. Automated maintenance of member information ensures that timely, accurate data are available to support all processes needing member information. Better internal controls improve level of identification of duplicates. Automation results in improved process efficiency. 7. Pennsylvania will implement a member portal that supports stakeholder interaction and allows for strategically

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		effective edits. System limitations and inconsistent retention of data require some manual validation. 7. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		managing improvements.
ME02 Manage Applicant and Member Communication	**1**	1. Pennsylvania uses a combination of automated and manual processes that can affect timeliness. The information is as accurate as the information given by the recipient. Eligibility management is much more automated than more complex recipient inquiries and billing issues. 2. Some communication processes are automated; however, manual intervention is also frequently required. 3. Research staff has decreased over the years. Automation has been utilized to increase productivity. 4. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.	**2**	1. Manual processes decrease as automation increases. Communication is more timely, effective, and accurate. General program information, provider, and information on health plans are available to applicants via websites. 2. Member communications are linguistically, culturally, and competency appropriate, but require considerable manual intervention for paper communications. 3. Improvements in member services and automation result in higher cost effectiveness than Level 1. 4. Pennsylvania will implement a member portal that supports stakeholder interaction and allows for strategically managing improvements. Stakeholders have no delay in obtaining responses and information is accurate.
ME03 Perform Population and Member Outreach	**1**	1. The average process time to review and approve/deny draft correspondence is approximately ten minutes per document. For the annual survey of adult service recipients and their families, the process takes several months. 2. Websites are used to disseminate information to existing and potential recipients. Other media such as television, radio, and pamphlets are used to target potential recipients. Statistical information is collected to monitor effectiveness. 3. Materials are functionally, linguistically, and culturally	**2**	1. Educational materials are distributed, end-to-end, in 1 to 2 weeks in a combination of written and electronic formats. 2. Effectiveness increases as programs are able to share analysis of current and prospective member demographics, socioeconomic status, and functional and health needs. Outreach materials are developed and stored in electronic format and made available to members via a Web portal, public media, or kiosks. Help lines and public advertising reach a broader population. 3. Materials also become competency appropriate.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		appropriate. 4. Statewide change centers reduce staffing requirements. Extensive use of web and other media reduces outreach costs related to potential recipients. An increased amount of mailings is required for MCO recipients due to their specific circumstances. Pennsylvania utilizes inserts to minimize mailing costs as much as possible. 5. Some measures are in place and utilized that enable the Commonwealth to determine the effectiveness of outreach effort. Pennsylvania uses multiple methods, including a web portal, for outreach efforts and collects information to monitor effectiveness.		Increased use of these materials improves content accuracy. 4. Automation results in proficiency in targeting populations needing outreach and education. Mailings are more accurate, transitioning to electronic distribution. Availability of online materials reduces paper and mailing costs. 5. Automated tracking yields some statistics. Use of portal by members is monitored, which results in better measurements. Stakeholders are found to be generally satisfied.
ME08 Manage Member Grievance and Appeal	**1**	1. Process is very manual. The Bureau of Hearings and Appeals (BHA) sends out some automated hearing scheduling notices but other issues require manual hearing scheduling notices. Some types of decisions issued by BHA are automated (those which are dismissed); however, an adjudication of most issues is completed manually and issued via United States Postal Service (USPS) mail. Maintaining, Preparing, and Processing Executive Reports (MAPPER) is the database that BHA uses to track the receipt of and disposition of appeals. 2. The process is compliant with timeliness requirements (e.g., Act 68) the majority of the time. 3. Complaints are generally resolved quicker than several months. Three percent (3%) or fewer overturned decisions. Timeframe varies by appeal type. Currently achieving 97% compliance	**2**	1. Documents are scanned and the case file is automated and can be shared among case workers. Access to available information is facilitated via Web portal and Electronic Data Interchange (EDI) channels using standard formats. Responses to requests to collect and verify member case information, and case management activities, are also automated. Results are documented and recorded automatically and can be accessed and reviewed as needed. 2. Automation in development of case file, scheduling hearings, and storing documents results in reduction in the end-to-end process time. 3. Standardized measurements are determined, improving member access, communication, and implementation of the grievance and appeal process. 4. Automation of some research steps increases productivity levels of staff required to

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		(goal is 100%). 4. The amount of manual effort needed to perform the process impacts cost-effectiveness, efficiency, and accuracy. 5. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		manage caseloads. Business rules are used to validate origin data. 5. The agency benefits from introduction of member portal and automation to speed up the case resolution. Stakeholders are satisfied.

3.4 Financial Management

3.4.1 Overview

The Financial Management business area is comprised of 19 defined business processes that support the finance, accounting, budgeting, and reporting functions of the PME. The core accounting functions, accounts receivable and accounts payable business processes, are initiated and performed by multiple business units throughout the PME. The accounts receivable process supports the collection and receipt of payments related to provider recoupments, estate and TPL recoveries, pharmacy drug rebates, cost settlements, member cost-sharing premiums payments, and FFP. The accounts payable business process supports the recognition and disbursement of payments related to providers and other Enterprise contracted vendor services, managed care capitation, services performed by other agencies insurers, and Medicare premiums. The budgeting business processes support planning, analysis, and decision-making activities related to operational performance, cost management, and information management. These processes all share a common set of financial-related data with the financial management business area responsible for the PME financial data store.

3.4.2 Financial Management As Is Summary

The PROMISe™ system is the MMIS for Pennsylvania. The primary financial interfaces to the MMIS include HCSIS; CIS; Systems, Applications, and Products (SAP); and the EDW. Data is shared across the enterprise using a mix of real-time and batch file exchanges.

Accounting Business Processes -- A variety of solutions are used for this area including outsourcing to another department within the Commonwealth or the use of Commercial Off-the-Shelf (COTS) packages to handle the accounting needs of the Enterprise. SAP is the PME general ledger and is the central data store for all financial transactions. Payment processes are managed by the Commonwealth Treasury Department's Automated Bookkeeping System (TABS). Systems across the PME including the MMIS, request payments by generating a payment file that is sent to TABS. Payments can take the form of checks or Electronic Funds Transfers (EFTs). Pennsylvania PROMISe™ will produce a Remittance Advice (RA) Statement for each provider who has had claims adjudicated and/or financial transactions processed during the payment cycle[7].

[7] PA PROMISe™ Provider Handbook - NCPDP 5.1/Pharmacy Billing

- The A***ccounts Receivable process*** supports the collection and receipt of payments related to provider recoupments, estate and TPL recoveries, pharmacy drug rebates, cost settlements, member cost-sharing premiums payments, and FFP.

  Generally, the process of identifying and initiating recovery of payments through the manage accounts receivables process is performed independently by a number of business units internal and external to the Enterprise. By consensus, the initiation part of the manage accounts receivable process is manual which involves identification and selection of claims overpayment and provider communications. The claims identification and selection process is performed using ad hoc queries sometimes across disparate systems using disparate data standards or non-HIPAA compliant transactions. Data is fragmented across multiple systems including PROMISe™, SAP, TABS and EDW and system updates to payment data are not available in real-time and are dependent upon the execution of scheduled system cycles. The manage cost settlement process also uses Excel and Word formats to prepare the cost reports themselves. Extracted queries must be reviewed manually for accuracy.

  Consensus also shows that once the accounts receivable has been manually entered into the PROMISe™ system, the degree of automation results in timely and accurate recoveries. However, information and data flows from varying business units within the Enterprise are in disparate formats. The Office of the Comptroller must accommodate interface design on a case-by-case basis to receive the information.

  The deposit/disposition of any paper-based payments to the PMA is the responsibility of the Comptroller Office. Paper checks related to refund payments are typically directed to the particular program office/agency responsible for generating the billing to which the receivable corresponds. The checks are transmitted to the Comptroller using a manual "request process" where confirmation by the Comptroller is returned to the initiating office or agency.

  For the majority of the manage accounts receivable process, and with the exception of manage drug rebate, stakeholder satisfaction is not monitored or measured and it does not identify opportunities for improvement.

- The ***Accounts Payable business process*** supports the recognition and disbursement of payments related to providers and other Enterprise contracted vendor services, managed care capitation, services performed by other agencies insurers, and Medicare premiums.

  Much like the manage accounts receivable business process, the manage accounts payable business processes share common themes. Multiple business units are responsible for initiating the process using disparate systems including PROMISe™, SAP, HIPP32, and the EDW. Systems data and systems data standards are fragmented and data formats are not consistent from one system to the next. In addition, the EDW does not store all of the data in a standardized format that promotes comparability across programs.

  The PROMISe™ and SAP workflows are not integrated and cannot share attachments and documents needed to support audit capabilities within the manage accounts payable business processes. Updates to payment data are not available in real-time due to scheduled system processing in batch cycles.

  There are also processing characteristics that are unique to certain manage accounts payable business processes:

- The ***Prepare Member Invoice process*** requires manual intervention to resolve PROMISe™/CIS interface issues. The CIS interface is not real time and demographic, eligibility, and premium change

information is inaccurate or unavailable. The member premium calculation is not automated nor is the tracking of accumulated cost share payments. The system is incapable of identifying missed or late member payments and there is no web enabled communication or account/payment information available to members.

- The ***Manage Incentive Payment process*** is a unique process to the PME. The MAPIR system which facilitates this process is a reusable, web-based product that is designed to interface with the provider and financial modules. The application was developed as an open architecture sourced system utilizing MITA principles through the collaboration of a 13-state consortium led by Pennsylvania to address the CMS EHR PIP. Payments are set up in the PROMISe™ system and transferred to TABS via the normal check write batch file for payment and distribution. The provider 1099 is automatically updated during this process. MAPIR contains 10 survey applications used to determine stakeholder satisfaction.

- The ***Manage Capitation Payment process*** utilizes the X12 820 premium payment transaction as a standard code set. However, as automated and efficient the payment process may seem using the PROMISe™ system, there is no rules engine to provide support for payment calculation or adjustment. Rates are entered and updated manually and retroactive adjustments that result in a negative payment must be entered manually using a credit gross adjustment. The gross adjustment establishes an accounts receivable that is recovered in the subsequent payment cycle.

- The ***Manage Member Premium Payment business process*** is reliant on the SSA interface file and the HIPP32 batch files to produce payment information. The process also uses the CIS to manage dual eligible information as it relates to eligibility. Manual processing is required for employer information exchange to pre-determine HIPP eligibility and manual intervention occurs only when there are data errors in the SSA file. Medicare member premium payments are set up through the normal PROMISe™ financial process cycle and Health Insurance Premium Payment (HIPP) payments are submitted directly to Treasury for payment processing.

Drug Rebate Business Process— Pennsylvania and its MCOs receive a batch file from CMS containing the rebate factors and drug codes quarterly by manufacturer (which is not always accurate). HPES is responsible for transmitting the PROMISe™ pharmacy claims history batch file, which includes the MCO encounter data to its subcontractor, Unisys, and the Federal Rebate Contractor.

Unisys is responsible for loading the claims data into Pharmacy Rebate Information Management System (PRIMS) for drug claim matching and selection, invoice generation, and tracking and reporting. Unisys uses NCPDP rebates standards during the process. During the drug claim matching and selection process, Unisys, assisted by the Commonwealth, must access and reconcile the Medicaid provider 340B exclusion list posted on the Health Resources and Services Administration (HRSA) website manually against paid claims. In addition, consideration must be given to the CMS utilization discrepancy report received via email which also must be reviewed manually for identification of needed drug coverage changes or system coding updates. The claims editing, processing, and monitoring for rebate eligibility is ongoing throughout the year. Once the drug rebate process is completed, the quarterly Pennsylvania drug claim utilization file generated from PRIMS is then transmitted back to HPES and the batch file is transmitted to CMS.

Rebate invoicing is performed quarterly and the process follows the federal mandate with regard to creating and distributing the rebate invoices which takes about 4 weeks. Roughly 900 drug rebate invoices are processed and mailed per quarter. While the production of the rebate invoice, claim level details, and

the CMS 64 reporting are automated, manual intervention is required to enter data for accounts receivable and check documentation maintenance.[8]

Checks from the manufacturers are submitted with the Reconciliation of State Invoice (ROSI) to the Comptroller's Office and the receivable is transmitted via manual process back to Unisys for confirmation that the invoice has been paid.

State-funded drug rebate programs are siloed and use non-standardized data and formats. As an example, the DOH administers the Special Pharmaceutical Benefits Program (SPBP), which provides pharmaceutical assistance and specific lab services to low and moderate-income individuals and families in need of drug therapies used for the treatment of persons with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) or a Diagnostic and Statistical Manual, of Mental Disorders, version 4 (DSM IV) diagnosis for schizophrenia. The HIV/AIDS portion of the program is funded through a combination of Ryan White Emergency Care Act Title II funds and state funds. The mental health drug component is funded exclusively through state funds.

DOH, through a Memorandum of Understanding (MOU) with the PDA uses Magellan Health Services (MHS), a contracted third party Pharmacy Benefits Management (PBM) contractor, to process pharmacy claims, perform enrollment/eligibility, and process drug rebates for the HIV SPBP. The DOH also uses MHS for several other programs administering pharmacy benefits.

Budgeting Business Processes — The Bureau of Information Services is responsible for maintaining the EDW. The EDW is the primary source of most data used in the budgeting process, although the data also exists and can be accessed in disparate systems (e.g., PROMISe™, CIS, and SAP) within the Enterprise. The data extraction process for financial reporting is complex. Ad hoc reports are created manually using Structured Query Language (SQL). Often times, queries built off of other queries are used to drill down further to access and analyze data in the reporting process. The data is received electronically, manually reviewed, placed into an Excel spreadsheet, and analyzed before delivery to the end user. The process takes several hours to several weeks based on the complexity and the time it takes for the requestor to define reporting requirements. Obstacles in accessing data from the EDW include time delays related to the frequency of data transfer from the MMIS to the data warehouse and the coordination and uniformity of data as it relates to any type of cross-program monitoring and reporting. The PMA is working toward creating more standard data definitions.

Pennsylvania's budgeting processes are ongoing to monitor and gather information for input to the development of the Governor's Executive Budget, new budget projections for the annual budget cycle, and annual surveys to identify MMIS-related activities that potentially qualify for federally matching funds. Some automation exists, but these are primarily manual processes. Data is gathered electronically through various data warehouses, data store queries, and spreadsheets which are used to solicit, gather, and confirm PMA budgeting information. The extraction of budget data from disparate systems again often makes data analysis difficult due to inconsistencies in data definitions from differing systems.

The operations involved with these programs were the primary focus of assessing this business area. Pennsylvania uses a variety of vendors to provide services ranging from drug rebates to TPL identification.

Numerous programs and business units within the Medicaid Enterprise perform or have a role in financial management. These include, but are not limited to:

- DOH
- DMVA

[8] Manage Drug Rebate Process Template

- DPW
  - OA
    - BIS
  - OB
  - OCDEL
  - ODP
  - OIM
  - OLA
  - OLTL
  - OMAP
    - BDCM
    - BFFSP
- Division of Pharmacy
    - BMCO
    - BPAP
    - OMAP Deputy Secretary's Office
    - OCQI
  - OMHSAS
  - OPD
- Governor's Office of Administration
- PDA
- PID
- U.S. Department of the Treasury
  - Office of Comptroller

3.4.3 Financial Management To Be Summary

Accounting Business Processes – A number of process improvements were identified. The majority of those recommendations for accounting business process improvements shared common themes to include improvements in; process duration and efficiency, interoperability, data exchange, data centralization, real-time updates vs. batch processing, data standardization and format including HIPAA standards, elimination of manual processes, elimination of siloed systems and processes, and better collaboration between business units.

Below are a number of prescribed improvements that are available to increase MMLs for the ***manage accounts payable process***:

- Move to as close to 100 percent EFT processing for all Enterprise payments as possible. The constraints of "Pay To" and religious and cultural barriers will be a priority driver.
- Implementation of EFT process or Electronic Bank Transfer (EBT) card to distribute HIPP for employers, members, and insurance companies
- The accounts payable/accounts receivable business processes must provide access to information related to the "Pay To" entity where any payment can be traced back to the source and reason for payment
- Implement audit trail functionality that provides traceability to reconcile EFT payments by service location, provider type specialty, and voucher number
- Consolidate payments into a single financial module. The process will start with Pennsylvania programs, and once stable, integrate other programs using Title XIX and XXI funds.
- Provide access via the web to the financial module to allow statewide access to authorized users via role based access

- Post 1099s and details on the provider/vendor web portal
- Explore data matching capabilities (e.g., IRS) to increase the accuracy and reduce mismatches during the 1099 production process

Below are a number of prescribed improvements that are available to increase MMLs for the ***prepare member invoice business process***:

- Develop a client participation process where clients financially participate in their health care costs and the exchange of account/payment data information for members is communicated using a web-enabled interface
- Automate premium payments with member's banks
- Improved batch interface between CIS and Medicaid Assistance for Workers with Disabilities (MAWD) so that member address and/or other demographics, eligibility, and premium amount changes and payment status are updated (preferably real-time if possible)
- Provide the ability to interface real-time with the USPS for address verification and validation
- Consider policy changes to improve consistency in closing eligibility for nonpayment of premiums
- Automate the member premium calculation in CIS in conjunction with target questions to obtain accurate information
- Automate the initial premium statement process

Below are a number of prescribed improvements available to increase MMLs for the ***Manage Cost Settlement business process***:

- Automate payment logic as much as possible. This includes pay for performance (P4P), cost settlements on risk arrangements, and other payment logistics.
- Focus on correcting system deficiencies to automate the cost settlement process
- Implement metrics and performance measures that capture the effectiveness of the cost settlement process using an automated dashboard and reporting process
- Establish a Web interface that is user role-based and will provide real-time access to claims information and other data while at the client site. The portal must support a standard set of audit workflow and user configurable business rules.
- Cost settlement amount is calculated both manually and automatically and submitted via an electronic process to OLTL
- Data is stored in a central repository and manages all cost settlement data
- Internal and HIPAA data standards are used (X12 837)

Below are a number of prescribed improvements that are available to increase MMLs for the ***Manage TPL and Estate Recovery business process***:

- Include legal and the comptroller in the TPL automated workflow review process
- Implement payer-to-provider and payer-to-payer TPL recovery process
- Utilize the Coordination of Benefits (COB) component to take advantage of payer-to-payer recoupment
- Explore creative methods for collections, including sending 1099s for debt collection to be reported as income
- Ability to reconcile all recoveries back to the original claims
- Establish electronic interfaces with external entities

Drug Rebate Business Process – Prescribed improvements include the ability to produce and transmit electronic invoices to the drug manufactures via a web-based portal interface for drug manufacturers to retrieve their electronic invoice on a quarterly basis, and to standardize the submission of drug rebate payments from the drug manufacturers to facilitate dispute processing and resolution.

Budgeting Business Processes — The ability to generate automated "what if" scenarios are a key capability for this business process. Tools are used to identify, expose, and standardize programmatic independent and dependent variables in the modeling process. Workflows are available to establish thresholds for submitting data to a central office where reviews and revisions can be made in real time. Below are a number of additional prescribed improvements available to increase MMLs for the ***Manage Budget related business processes***:

- Dashboard capabilities are integrated and centralized into the policy development and reporting module to support more dynamic collaboration of policy and reporting. This functionality must include workflow for routing, searchable content to retrieve data, maintain an audit trail of when the decision was made and who made it, and maintain historic reference. For example, statute review and development would be supported through search capabilities, edit form, routing of review and approval, and guidance on impact and related statute/regulation.
- The EDW, provider member reference, and other external data sources are integrated into the financial module to the highest degree possible to provide real time analysis and information. Integration of data will be phased over time, focusing on increasing levels of complexity. Integration is performed focusing in on data standards and formats to support easy-to-use interfaces and standard queries.
- Include Metadata in the EDW that provides meaningful and comprehensive definitions and caveats for each data item maintained. Create crosswalks that trace each EDW data element back to its PROMISe™ source (e.g., a claim form, a transaction loop/field name) and configure any changes that might occur from the source to the data warehouse.
- To the extent possible, incorporate all Enterprise data in the EDW including provider enrollment, reference, TPL/COB, and error status code.
- Provide user education and training on how to interpret and accurately identify and extract source data from the EDW for reporting purposes.
- Provide enhanced functionality to manage the Federal Medical Assistance Percentage (FMAP) and FFP business process and develop an automated reporting tool to monitor program performance using strategic performance measures. Improve the ability to monitor broad situational awareness and event surveillance and share this information across the enterprise.
- Integrate Generally Accepted Accounting Principles (GAAP) into all analysis and reporting capabilities

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 7: Financial Management Maturity Level

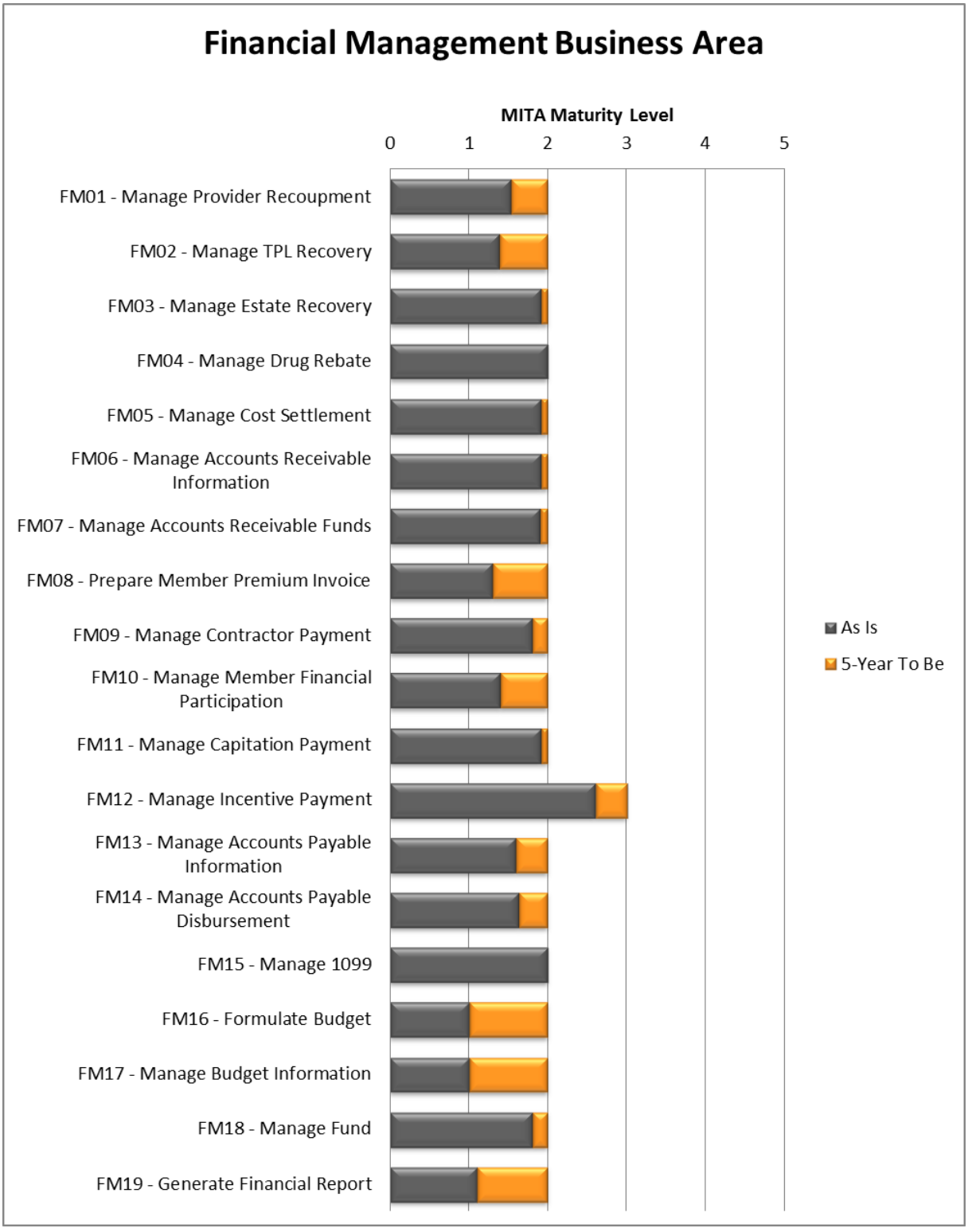


Table 5: Financial Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
FM01 Manage Recoupment	**1**	1. Provider notification of overpayment initiated by the PMA is usually a manual process using paper correspondence in some instances. 2. Payer to payer model is not supported. 3. The process of identifying and initiating recovery is primarily manual however; after system entry the automation results in timely and accurate recoupment of payment. 4. There are many organizations internal and external (hired contractors) to the Enterprise that has a hand in initiating the recoupment processes. 5. Automation to coordinate the use of data (flagging of claims already under review by other organizations within the Enterprise) is not available to all who use it. 6. Data retrieval quality can be inconsistent or access to information is not available at all.	**2**	1. Electronic correspondence is used to communicate overpayments to providers. 2. Payer to payer model is introduced and supports this process. 3. The recoupment identification and initiation business processes are automated into an integrated, centralized workflow or service, for entry into the MMIS. 4. System data is accessible to internal and external participants involved in managing the recoupment process. System data is integrated and centralized and process workflows are coordinated within the Medicaid Enterprise. 5. The entry of capitation rates is now automated.
FM02 Manage TPL Recovery	**1**	1. Electronic HIPAA transactions are not used in identification of possible TPL. 2. Primarily uses the pay and chase model. 3. Post payment recovery is done through a paper claim process, though some 837 billing is done by Healthcare Management System (HMS). 4. In-house claims selection process is lengthy and requires a modification to the ad hoc query request for selection within the recovery pool. 5. Requires the manual	**2**	1. Internal and HIPAA data standards and transactions are implemented. 2. Process is a mix of automated and manual process steps. 3. Process has been centralized. 4. TPL recovery activities are both payer-to-provider and payer-to-payer.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		review of claims data and other documentation to verify the TPL recovery process l.		
FM03 Manage Estate Recovery	**1**	1. Pennsylvania uses paperless case files for all newly opened Estate Recovery cases. 2. Process is manual with automated system support of information management. 3. Process is constrained by legal requirements requiring paper communications.	**2**	1. The process is a mix of automated and manual with few paper procedures. 2. Electronic interfaces exist with external entities.
FM04 Manage Drug Rebate	**2**	1. The front end data matching process can be manual at times however; the entire process is primarily automated. 2. Data received from CMS is not always accurate (e.g., termination dates and Drug Efficacy Study and Implementation (DESI) codes) and can slow the process. 3. The process meets accelerated Commonwealth timeframes and established performance measures have been achieved the previous two years. 4. Pennsylvania uses a federal rebate contractor that utilizes the NCPDP rebates standards. 5. Commonwealth-funded drug rebate programs are siloed and make use of non-standardized data and formats. 6. The Managed Care Plans sometimes do not send their information timely or in the correct format. 7. Stakeholder satisfaction is tracked and measured.	**2**	1. The process continues to be primarily automated. 2. Continued use of National data standards to process drug rebates. 3. Process continues to meet or exceed timeliness and efficiency performance measures. 4. Commonwealth funded drug rebate programs are integrated and use standardized data and formats. 5. MCO data and format submissions containing drug rebate information are consistent. 6. Stakeholder satisfaction is tracked and measured.
FM05 Manage Cost Settlement	**1**	1. The process is a mix of manual and automated steps. 2. Microsoft Excel and Word	**2**	1. Cost settlement amount is calculated both manually and automatically. 2. Central repository stores and

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		are used to prepare the cost reports. 3. Microsoft Access is used to manage data. 4. Cost report data is received electronically, but requires manual review and analysis. 5. Gross Receipts Tax and Hospital Assessments are managed through PROMISe™ with some manual intervention. 6. Stakeholder satisfaction does not appear to be measured or tracked. 7. Opportunities for improvements are not proactively identified.		manages all cost settlement data. 3. Internal and HIPAA data standards are implemented. 4. Process is a mix of manual and automated process steps. 5. Stakeholder satisfaction is tracked and measured.
FM06 Manage Accounts Receivable Information	**1**	1. Data is fragmented across multiple systems including PROMISe™, SAP, TABS, and EDW. 2. Updates to payment data are not available in real-time, requires scheduled system cycles. 3. Not all data is stored in a standardized format that promotes comparability across programs. 4. Information and data flows from varying business units within the Enterprise are in disparate formats. The Office of the Comptroller must accommodate interface design on a case-by-case basis to receive the information. 5. Stakeholder satisfaction does not appear to be measured.	**2**	1. Data sources are primarily electronic interchange such as EDI, Point of Service (POS), and web portals. 2. Automation has increased due to standardization of data across the PME. 3. Less verification is required and more calculations have been automated. 4. There is an automated nightly update between the MMIS and the Commonwealth accounting system for all accounts payable and accounts receivable activity in both systems. 5. HIPAA and internal data standards are implemented. 6. Payment process is centralized and coordinated across the PME. 7. Stakeholder satisfaction is measured and tracked.
FM07 Manage Accounts Receivable Collection — Refund	**1**	1. The accounting function uses a mix of manual and automated processes. 2. Data is fragmented across multiple systems including PROMISe™, SAP, TABS, and EDW 3. Complies with Code of Federal Regulations (CFR) 45, Cash Management Act, and	**2**	1. A mix of manual and automated processes is used to complete the business process. 2. GAAP supplements CFR 45 Cash Management Act and GASB standards. Financial information has been standardized across the PME and COTS packages are certified compliant with all standards. 3. HIPAA standards and electronic

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		Governmental Accounting Standards Board (GASB) standards. 4. The deposit/disposition of any paper-based payments to the PMA is the responsibility of our Comptroller Office. Paper checks related to refund payments are typically directed to the particular program office/agency responsible for generating the billing to which the receivable corresponds. The checks are transmitted to the Comptroller using a manual "request process" where confirmation by the Comptroller is returned to the initiating office or agency. 5. Revenue collection (Nursing Facility Assessment and Hospital Assessment) electronic payments typically circumvent Comptroller initially; these payments are directly reported by the Department's Budget Office to PA Treasury, where Treasury would later reconcile with Comptroller. 6. There is significant control and oversight in receiving checks. 7. The Commonwealth is moving toward an all EFT format for institutional payment submissions. 8. Stakeholder satisfaction is not being tracked and/or measured.		payment processing are adopted to complete financial transactions. 4. Process timeliness is improved through use of automation and exceeds legal processing requirements. 5. Accuracy and consistency of data used in the process are improved due to the use standards and increased automation. The process uses online access to data. Real-time data access may be limited. 6. The PME has implemented processes in some areas to track stakeholder satisfaction, expectations, and priorities.
FM08 Prepare Member Invoice	**1**	1. Vouchers are paper. 2. Manual intervention is required to resolve PROMISe™/CIS interface issues. 3. The CIS interface is not real time and demographic, eligibility, and premium change	**2**	1. Invoices are a mix of paper and electronic. 2. Process is mostly automated with few manual exceptions. 3. Interfaces between systems are automated and information can be viewed real-time. 4. Internal and HIPAA data standards are implemented.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		information is inaccurate or unavailable. 4. Automation of the tracking of cost share payments is minimal. 5. The member premium calculation is not automated. 6. Some systems in the process cannot accept electronic transactions at all. 7. Systems do not identify missed or late member premium payments during the invoicing process. 8. There is no web-enabled communication or account/payment information available to members. 9. Stakeholder satisfaction does not appear to be measured and identification of opportunities for improvement is not proactively identified.		5. Stakeholder satisfaction is measured and tracked.
FM09 Manage Invoice Payment	**1**	1. The process is a mix of manual and automated steps. The data is received electronically but must be manually evaluated and entered in SAP. Invoice payments by contract are tracked manually. 2. The Supplier Relationship Workflow Management system automates the review, validation, and approval of the invoice payment. 3. Stakeholder satisfaction is not monitored or measured.	**2**	1. The process is automated with some manual intervention. 2. Increased real-time updates to payment data. 3. HIPAA and internal data standards are implemented. 4. Information is contained in disparate systems but additional improvements in automation improve the business process. 5. Stakeholder satisfaction is measured and tracked.
FM10 Manage Member Premium Payment	**1**	1. The process is predominantly automated. Manual intervention only occurs when there are data errors in the SSA interface file. 2. Information exchange with employers is manual. 3. Cases are managed as a	**2**	1. Cases are managed in a central location. 2. Payments are generated through a mix of EFT and paper checks. 3. Process is a mix of manual and automated process steps. 4. Case identification is becoming more automated and transfer of information is automated through

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		separate program. 4. Payments are made through a paper check process. 5. Case identification is primarily manual and paper-based. 6. Batch file transactions are used to transfer information (HIPP32 System). 7. Process for resolving conflicts can be time consuming and require manual intervention. 8. CIS is used to manage dual eligible information. 9. Stakeholder satisfaction does not appear to be measured and identification of opportunities for improvement is not proactively identified.		interfaces. 5. Data is HIPAA compliant, uses internal data standards and transactions, accurate, electronically accessed, and represents the most current information available. 6. Process is completed in fewer than 10 days. 7. Stakeholder satisfaction is tracked and measured.
FM11 Manage Capitation Payment	**1**	1. Process uses the X12 820 premium payment transaction. 2. Process is primarily automated however, rates are entered and updated manually 3. Process uses a hard-coded algorithm with some variable support. 4. Retroactive adjustments that result in a negative payment must be entered manually using a credit gross adjustment. The gross adjustment establishes an AR that is recovered in the subsequent payment cycle.	**2**	1. Process continues to be mostly automated. 2. Business rules are automated. 3. Internal and HIPAA data standards are implemented. 4. Automate rate entry 5. Stakeholder satisfaction is measured and tracked.
FM12 Manage Incentive Payments	**2**	1. MAPIR is a reusable Web-Based application that is designed to interface with the provider and financial modules. 2. The CMS National Level Repository (NLR), Registration and Attestation System (R&A) has established data transmission standards.	**3**	1. Electronic collection of clinical data at the aggregate and individual levels through the HIE. 2. Develop MAPIR and business process for stage 3 Meaningful Use by 2016. 3. Stakeholder satisfaction is monitored and measured.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		3. Pennsylvania leads a 13-state consortium for MAPIR. 4. The MAPIR application is an open architecture sourced system. 5. MAPIR contains 10 survey applications used to determine stakeholder satisfaction.		
FM13 Manage Accounts Payable Information	**1**	1. Multiple business units are responsible for initiating the process using disparate systems. 2. The PROMISe™ and SAP workflows are not integrated and cannot share attachments related to supporting accounting documentation. 3. Data is fragmented across multiple systems including PROMISe™, SAP, HIPP32, and EDW. 4. Updates to payment data is not available in real-time, requires scheduled system cycles. 5. Adoption of e-Signature has not occurred. 6. Not all systems share information using internal data standards. 7. Not all data is stored in a standardized format (EDW) that promotes comparability across programs. 8. Stakeholder satisfaction does not appear to be measured.	**2**	1. Data sources are primarily electronic interchange such as EDI, POS, and web portals. 2. Increased real-time updates to payment data. 3. Workflows are established between systems to share attached documentation. 4. Adopt the e-Signature. 5. HIPAA and internal data standards are implemented. 6. Payment process is centralized and coordinated across the PME. 7. Stakeholder satisfaction is measured and tracked.
FM14 Manage Accounts Payable Disbursement	**1**	1. Batch files from disparate systems are used for distribution of payment. 2. Paper checks are costly and maintaining accurate address information is a challenge. 3. A mix of EFTs and checks are used. 4. HIPP premiums are 100% paper checks. 5. EFT transactions are compliant with state and industry, and are HIPAA-	**2**	1. EFTs is the primary method of payment for providers with very few paper checks produced. 2. Implement real-time interface with USPS system for address validation and verification. 3. Stakeholder satisfaction is tracked and measured. 4. EFTs is the main method of payment with paper checks being the exception. 5. The process is a mix of manual and automated. 6. HIPAA and internal data

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		compliant where appropriate. 6. Stakeholder satisfaction is not monitored or measured and opportunities for improvement are not proactively identified.		standards are implemented. 7. Process time is completed in weeks rather than months.
FM15 Manage 1099s	**2**	1. Data retrieval, 1099 production, and reports are performed electronically, but are manually evaluated for accuracy. 2. 1099 production is split between the OMAP PROMISe™ and Comptroller SAP systems. 3. 1099s are produced on paper and mailed as there is no capability to post 1099 details on the provider/vendor web portal. 4. The 1099 electronic batch file uses federal standard format. 5. The PME has agreements for common processes to achieve economies of scale and increase coordination. 6. The data validation (research data discrepancies) process can take several days before releasing the 1099s. Data is reasonably accurate. Errors result from improper maintenance of the provider data store or inaccurate data provided by the IRS. 7. The process meets the federal and Commonwealth timeframes for timeliness and submission. However, stakeholder satisfaction is not monitored or tracked.	**2**	1. Automation of process steps has increased. 1099s can now be posted to the provider portal for retrieval or delivered via secure email. Mailed paper 1099s are the exception. 2. Data has been standardized across the PME. 3. Collaboration has improved to the point that the management of 1099s is now part of a single centralized process within the PME. 4. Data matching capabilities improve using better data collection tools and better maintenance and standardization of data across the PME to eliminate the need to manually verify 1099s prior to releasing them for distribution. Timeliness improves. 5. Policy requiring that providers maintain their contact information via the provider portal and standardization of data reduces errors. Data is readily available online. 6. Stakeholder satisfaction continues to improve, based on the monitoring and tracking of performance measures, with fewer errors in provider contact information.
FM16 Formulate Budget	**1**	1. The process is a mix of manual and automated steps. 2. Disparate systems are	**2**	1. Analysis to support formulating the budget has become highly automated supported by COTS predictive modeling and

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		used to collect data from various data stores and the EDW. 3. Existing budget models in Excel format are updated and used to analyze the budget data stored in disparate systems. 4. Significant effort is spent on data manipulation 5. The extraction of data from disparate systems often makes data analysis difficult due to inconsistencies in data standards and definition and introduces opportunities for error. 6. There is no automated process for updating budget projections for the 4 major budget updates in the annual budget cycle. 7. Stakeholder satisfaction is not being tracked and/or measured.		expenditure forecasting tools. 2. The process is a mixture of automation and manual intervention to gather financial information and cost projections. 3. The need to verify data has been greatly reduced due to the implementation of data standards and definitions for financial information across the PME. 4. Additional automation allows time for increased analysis and improved results. 5. The PME has implemented processes in some areas to track stakeholder satisfaction, expectations, and priorities. Improvements are made strategically, increasing stakeholder satisfaction.
FM17 Manage Budget Information	**1**	1. The process is a mix of manual and automated steps. 2. Disparate systems are used to collect data from various data stores and the EDW. 3. Existing budget models in Excel format are updated and used to analyze the budget data stored in disparate systems. 4. Significant effort is spent on data manipulation. 5. The extraction of data from disparate systems often makes data analysis difficult due to inconsistencies in data standards and definition and introduces opportunities for error. 6. There is no automated process for updating budget projections for the four major budget updates in the annual budget cycle. 7. Stakeholder satisfaction	**2**	1. The process is a mixture of automation and manual intervention to gather and audit financial information and cost projections. 2. The need to verify data has been greatly reduced due to the implementation of data standards and definitions for financial information across the PME. 3. Additional automation allows time for increased analysis and improved results. 4. Stakeholder satisfaction is measured and tracked.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		does not appear to be measured.		
FM18 Manage Fund	**1**	1. PMA uses a mix of manual and automated processes to manage funds. 2. Use of COTS products to support MA financial functions improves ability to access information, analyze, and make decisions regarding allocation and reporting. 3. PMA performs reconciliations and monitors the use of state funds on a weekly and monthly basis to insure accuracy and provide sufficient time to take corrective action as necessary. 4. Data is reasonably accurate, but can be improved. Anomalies can occur when data is extracted from the data warehouse. Queries must be developed carefully to ensure that appropriate information is extracted. Obtaining data and preparing reports is mostly a manual process. 5. The process is difficult to change because rules must be manually updated and actions are tightly coupled. 6. The expenditures and budget are monitored on an ongoing basis to ensure timeliness of reports, later. 7. Between MMIS and SAP data is readily available, current, and accurate. 8. A limited number of resources are used to create the CMS-37. However, the process is manually intensive. The CMS-64 and drawdown processes are predominately	**2**	1. An Enterprise solution has been implemented to centralize and standardize data needed to manage the FFP computation for DDI or operation of the MMIS. 2. Financial data is standardized across MMIS, SAP, and any COTS applications and improves support for access to information, data analysis, and decision-making. 3. Less verification is required and more calculations have been automated. There is an automated nightly update between the MMIS and the Commonwealth accounting system for all accounts payable and accounts receivable activity in both systems. Staff still uses reports to determine the amount for each draw. Monitoring state funds on a periodic basis is more automated. 4. Process is more efficient, but still requires staff involvement for activities that could be automated. Further automation of analysis improves cost efficiency, allowing staff to become even more proactive in managing state funds. 5. Increased automation of process steps and standardization of data increases the accuracy of process results. 6. Ad hoc queries and file extracts are coordinated and integrated into standard budget models. The process allows strategic and data sensitive elements to be easily updated using an integrated, systematic, and automated approach. 7. The Medicaid enterprise meets its goals for obtaining FFP for services with few adverse audit results due to increased process automation. 8. The PME has implemented processes in some areas to track stakeholder satisfaction, expectations, and priorities. Improvements are made strategically, increasing

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		automated. 9. The manual processes require reiterative calculations and verifications until the FFP for services request is completed. This process takes the full time allotted by federal standards (i.e., one quarter) to prepare. 10. Data is a mixture of detailed cost based upon billings for systems and estimated data for administrative support functions (FFP survey, time entry). There are manual process steps that can lead to inaccuracies in data. The process requires multiple efforts to access information from many sources. 11. Requires multiple iterations for documenting the FFP for DDI or operation of the MMIS. 12. The process is reasonably efficient but, still requires some manual effort. As a result the process is not as cost efficient as it could be. Automation frees some time for staff to focus on analysis of the data, projections, and recommendations for improvements in allocation formulas. 13. The process is highly accurate, but manual intervention to verify accuracy is required. Audit results have validated the accuracy of process results. Results meet the needs of the agency for the draw of FFP.		stakeholder satisfaction of the process steps and standardization of data increases the accuracy of process results. 9. The PME meets its goals for obtaining FFP for services with few adverse audit results due to increased process automation. 10. The PME has implemented processes in some areas to track stakeholder satisfaction, expectations, and priorities. Improvements are made strategically, increasing stakeholder satisfaction.
FM19 Generate Financial	**1**	1. Ad hoc reports are created manually for this process using SQL. Data	**2**	1. This business process uses a mix of manual and automated process steps. Queries can be

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
Reports		is received electronically, then again, manually reviewed, placed into an Excel spreadsheet, and analyzed before delivery to the end user. 2. Process duration is a few hours to several weeks based on the complexity and the time it takes for the requestor to define reporting requirements. 3. Access through the data warehouse involves a time delay related to the frequency of data transfer from MMIS to the data warehouse. Uniformity of data is uncoordinated; non-standardized data makes any type of cross program monitoring, reporting, and analysis difficult. Working toward more standard data definitions. 4. The degree of manual intervention makes the process less cost-effective. 5. The Medicaid enterprise uses the output of the reports but must adjust data and impose +/- % accuracy caveat. The process does not introduce additional error. 6. Stakeholders lack confidence in information used to generate financial reports, resulting in manual intervention to verify query results.		standardized and automated and the need for manual analysis reduced due to standardization of data across the Medicaid enterprise. Automated workflow capabilities alert users to availability of reports. 2. Due to standardization of data definitions more reports can be automated and easily modified. Requestors have a better understanding of the data so requests for new reports take less time to implement. Standard reports are produced on schedule within a day and most new requests can be completed within a day. 3. Standardization of the data has synchronized all the data necessary to generate the financial and program analysis reports. Validation of data content is automated, for the most part. 4. Standardization reduces the cost to generate the financial and program analysis report and the quality of the process increases. More agencies and entities agree to share information electronically with Medicaid agency which improves content. 5. Standardized methodologies and data produce a more accurate and useable financial and program analysis reports. Standard methodologies have defined the non- centrally located sources for the information needed to generate the financial and program analysis report. 6. Standardization has provided more clear and useful information for stakeholders. Satisfaction increases with the decrease in the need for manual intervention.

3.5 Operations Management

3.5.1 Overview

The Operations Management business area is collections of business processes that manages claims, encounter claim data, calculates payment amounts, and generates RA statements. This business area uses a specific set of claims-related data and includes processing (i.e., editing, auditing, and pricing) a variety of claim formats including professional, dental, institutional, drug, and encounters, as well as sending payment information to the accounts payable process. All claim processing activity incorporates compatible methodologies of the NCCI. The Operations Management business area is responsible for the claims data store.

3.5.2 Operations Management As Is Summary

There are several business areas within the PME supporting the various business processes within operations management. While over 80 percent of the Pennsylvania Medicaid population is enrolled in Managed Care for care management, the remainder of the population is managed by the FFS, waiver, and LTC programs. The operations involved with these programs were the primary focus of assessing this business area. The Commonwealth's FA, HPES, performs the majority of the operations management tasks.

Data shared across the Enterprise is a mix of real-time and batch file exchanges. PROMISe™ is the MMIS for Pennsylvania and has real-time interfaces with the Pennsylvania MCI, MPI, CIS, HCSIS, and Geographical Interface System (GIS). Managed care enrollment in the Commonwealth is approximately 81.5 percent[9] accounting for the vast majority of claims as claim encounters. Claims are adjudicated in real-time and are then bundled into a weekly batch payment cycle. There are around 2,000 edits or audits within the MMIS as part of claims processing logic. Business users can adjust some business rules within PROMISe™, but other complex changes to business rules require a Change Order. The weekly claims payment cycle includes paying professional, institutional, long-term, dental, and pharmacy claims. Approximately 1.4 million encounters are also processed weekly through the MMIS using similar edit, audit, and valuing methodology. Currently, 97 percent of the approximately 1.0 million weekly FFS claims are submitted using standard electronic transactions. However, other HIPAA transactions have a much smaller adoption and use rate across the Enterprise. The processing of encounter claims is highly automated using nation standard formats.

Several processes continue to be heavily paper-based. The claim attachment process continues to be primarily paper based with some electronic capabilities. Providers continue to choose paper documentation as a method of sending supporting documentation. The RA process is highly automated with electronic RA options available using national formats. A large number of providers are still requesting paper versions of the RA.

The MITA 3.0 framework has nine Operations Management business process. Pennsylvania included three additional and unique business processes as part of its 2011 MITA As Is Assessment. Cognosante reviewed the three processes and concluded that two of the processes are still performed. A third process included in the 2011 MITA SS-A, Manage Co-Pay rebate, is no longer performed, and has been dropped

[9] Medicaid Managed Care Enrollment Report, Centers for Medicare and Medicaid Services, U.S. HHS, November 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

from the assessment. The unique processes include OM30 – Manage Drug Rebate Dispute Resolution and OM31 – Manage Payment of Non-Emergency Transportation.

Numerous programs and business units within the Medicaid Enterprise perform or have a role in operations management. These include, but are not limited to:

- DOH
- DMVA
- DPW
  - OA
    - BIS
    - BPI
      - TPL
  - OCDEL
  - ODP
  - OIM
  - OLTL
  - OMAP
      - BDCM
      - BFFSP
      - BMCO
      - BPAP
      - MATP
  - OMHSAS
- HPES
- IPRO
- MCOs
- Mercer

Outside the Medicaid Enterprise, numerous other programs have a role in a number of processes associated with this business area. This is especially true for any program that covers targeted services for eligible members, receives requests for payment for services rendered, processes payment requests, and makes payments.

Of the 11 Operations Management processes, 9 are at a Maturity Level 1, with the remaining 2 processes at a MML 2.

The primary factors affecting maturity ratings across the Operations Management Business Area include the following:

- Most processes are a combination of manual and automated activities
- The manual processes are well documented and repeatable which improves the accuracy
- The process of resolved suspended claims has a high degree of manual effort
- Stringent timelines put in place have reduced the time to process suspended claims
- There is an increased use of data exchanges utilizing national standard formats
- The use of automation has improved the timeliness of the processes
- The electronic claim attachment process is time consuming and may take up to 14 days to process the claim
- Stakeholder satisfaction is improving due to the automation improving the accuracy of the data. The overall satisfaction remains low due to several highly manual processes.

3.5.3 Operations Management To Be Summary

As established during the Commonwealth's EVS, this business area is considered a medium priority for capability improvements. As a result, the resources dedicated to improvements to this area will be made available once higher priority areas such as Member Management, Care Management, and Program Management have been addressed. The Commonwealth will focus on making improvements to sharing data, consolidating redundant and fragmented data sources, promoting self-service for users, and managing stakeholder satisfaction.

The Pennsylvania goals for Operations Management as determined during the EVS are as follows:

- Achieve total electronic transaction processing
- Achieve MITA SOA where feasible
- Develop policy changes to enable full automation
- Enhance Drug Rebate Program processes. FFS is all-inclusive but the MCOs are lagging behind
- Interface with future electronic health/medical records systems.
- Automated standard web interfaces with internal and external entities in a browser-based environment

Additional functional capability improvements for Operations Management include the following:

Policy Review:

- Comprehensive policy review and update to support electronic transactions
- Comprehensive policy review to ensure content of submitted documents meets current and future business needs
- Review policy to streamline rate setting and pricing to try to minimize mass adjustments
- Review current claims adjudication policy to ensure it aligns with current and future business requirements
- Review pricing policy and methodologies and build alignment and consistency
- Review current payment processes and align with a single payment methodology, (e.g., identify Veteran's Homes and Mental Health (MH)/Mental Retardation (MR) payments as a COB so the appropriate payment is made
- Review policy, legal, and other considerations to ensure that any workflow or system functionality makes sense based on current and future business needs, e.g., currently, the information change process is cumbersome. Security will need to be a key driver to IT decisions, including existing security interfaces
- The HIPAA 5010 276 will need to be analyzed to determine if it provides the level of information needed for widespread use by providers
- Review and analyze the current PME web content model to make information easier to maintain and easier to retrieve
- Movement to electronic attachments will require Return on Investment (ROI), cost benefit, and feasibility studies

Training and Outreach:

- Include provider education and outreach at the point of RA viewing to try to proactively answer questions

Provider Web Portal:

- Claims attachments are submitted through the Provider web portal where validation of standard attachment content occurs
- Web-based provider portal that interfaces and allows submission for requests including submission of clinical information

- The portal must support multiple format downloads based on the 835 layout
- Available to all providers to download and translate X12 transactions (this could be a common web service as part of the provider portal functionality)
- Promote self-service functionality where periodically the "Pay To" will need to verify their address, bank information, and other information before receiving next payment
- Ability to link electronic documents
- Integrate to the HIE to access and utilize EHR capabilities

Claim Attachments:

- Implement as close to 100 percent as possible electronic claims attachment
- Interface with future electronic health/medical records systems
- Expand training in the claims adjustment process and consider a more robust role based limitation for complex adjustments

Claims Adjudication:

- Integrate all health care claims through a single claims adjudication process. This will include reaching out to sister agencies, atypical providers, and other non-health care providers.
- Acquire as close to 100 percent electronic claims submission as possible
- Move edits to a user configurable rules engine where edit policy is presented in plain English
- Implement "what if" environment that will provide sandbox capabilities to look at "what if" scenarios including testing policy decisions for fiscal and other impacts
- Enhance the edit/audit capabilities to support payments based on health outcome model
- Integrate claims and encounter processing to provide a statewide view for editing and auditing
- System must also support dashboard capability, query, and reporting requirements
- Support user configurable business rules with enhanced audit capabilities
- Take advantage of integrated eligibility opportunities to update the adjudication pricing model for claims and encounters. This will need to ensure consistency across all claims and reimbursements.
- Functionality must continue to support the ability for user configurable rate adjustments and batch uploads
- Build backup and redundancy into the architecture to support Continuity of Operations (COOP)
- Enhance the user configurable mass adjustment user interface (UI) to include more variables to support more complex adjustments

Payment Processing:

- Work to mandate 100 percent electronic transactions, with additional focus on promotion of using electronics

Payment Status:

- Functionality could start with making the check date information available to the provider community
- Achieve total electronic transaction processing
- Achieve MITA SOA where feasible
- Automated standard web interfaces with internal and external entities in a browser-based environment
- Integrate provider resolution guidance through web links (denial reason codes could be hyperlinked to that section of the provider manual)

Drug Rebate Dispute Resolution:

- Automation improves the timeliness of the resolution
- Increase the use of standardized data

Other:

- Future system design needs to take into account the realities of extremely small and rural practices and practices that refuse to change their processes. Although some manual processes may remain, access to care should not be compromised.
- Implement a policy development environment where "what if" adjustments can be made and tested before being done in the production environment
- Review the HIPAA 5010 835 to determine if the additional information has been added (denial reason code)
- Implement workflow management system that would include:
  - Automatic ticklers and alerts
  - Trigger to automate production of ad hoc initial premium statement
  - Dashboard views
  - Ensure that the process for provider referrals includes capabilities needed for MCOs
- Integrate the Corticon rules engine into the rate setting and adjustment process
- Retro rate process must be consistent across all claim types
- Promote consistent application of policy and tools through a user configurable business rules engine
- Review the HIPAA 5010 U277 and NCPDP D.0 to determine if PROMISe™ pricing and other data can be included in the transaction
- Develop processes to improve quality of MCO data including translation guidance and post transmission audits
- Implement robust document management system that can interface with the authorize service/referral/treatment plan system to increase automation
- Integrate National Provider Identifier (NPI) as the identifier of record for all claims and encounters. Planning for integration and consolidation will need to occur to create the most effective provider data model (MPI, PROMISe™, and NPI).
- Enable the metrics from this process to be viewable dashboard items
- Implement internal, enterprise-wide data standards
- Implement business logic to take advantage of clinical data available through ICD-10
- Consolidation of data will require collaboration, partnering, data use agreements, incentive, and directive

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 8: Operations Management Maturity Level

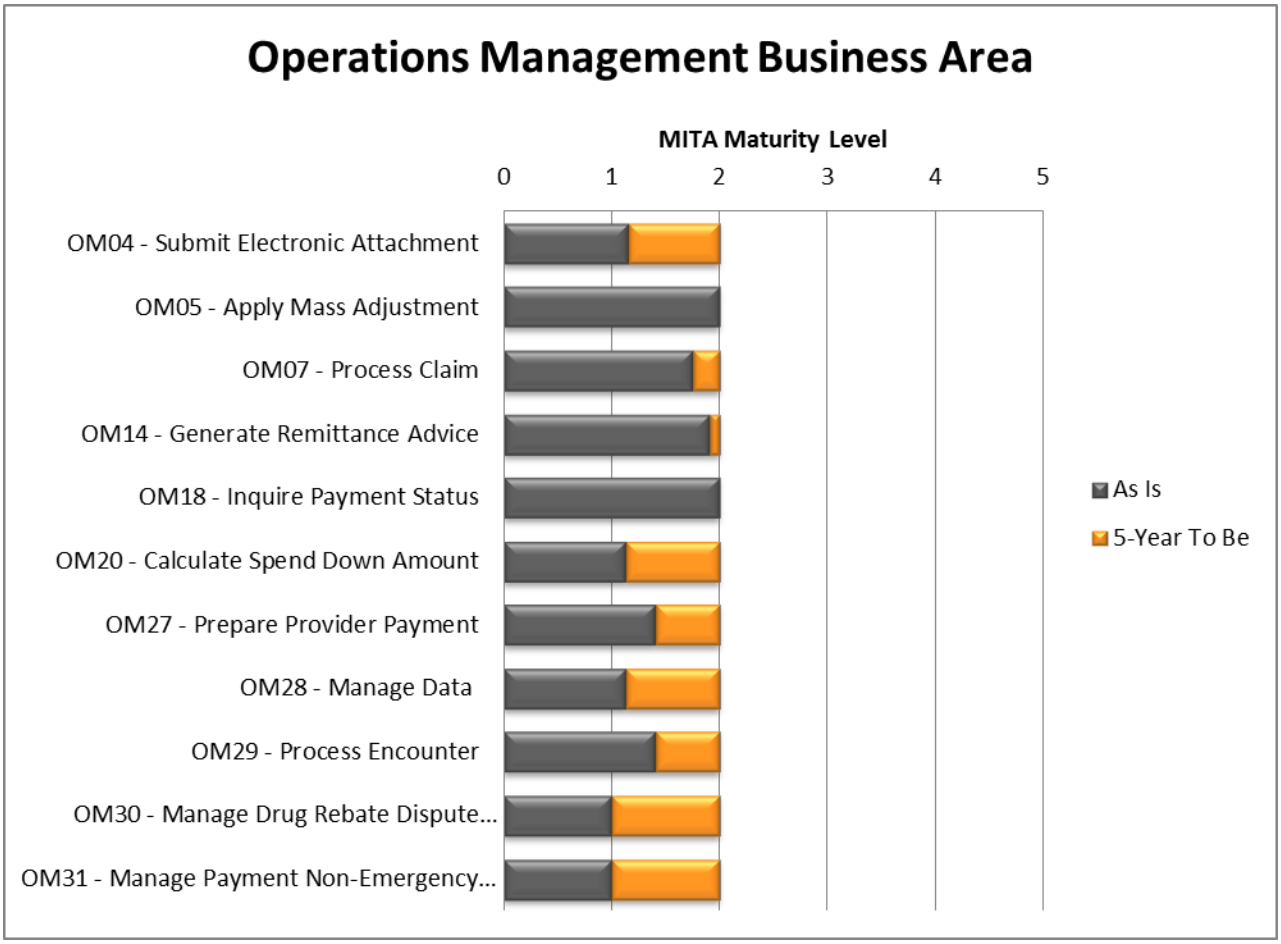


Table 6: Operations Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
OM04 Submit Electronic Attachment	**1**	1. Paper attachment documentation continues to be the primary method used for submission. 2. HIPAA standards for requesting additional information and receiving electronic attachments are not yet nationally adopted. 3. Electronic attachments are not widely accepted across the Medicaid Enterprise. 4. Additional information is not requested when applying attachments to claims. 5. The 275 transaction (Patient Information) is not currently used in Pennsylvania. 6. Handling of attachments requires manual review of data to determine appropriateness of information. 7. Stakeholder satisfaction remains low due to the labor intensive manual process.	**2**	1. Attachments are a mix of paper and electronic attachments. 2. HIPAA standard transactions have been be adopted. 3. The process leverages existing functionality with Rx attachments. 4. Process steps are a mix of automated and manual. 5. The process requires 24 hours or less to receive clinical attachment and associate with correct transaction. 6. Clinical records can be accessed in an hour or less. 7. The interface with HIE/EHR has reduced the need for electronic attachments. 8. Stakeholder satisfaction has improved with the increased use of automation.
OM05 Apply Mass Adjustment	**2**	1. Mass adjustments can be completed by business users through PROMISe™. 2. Online functionality is very easy to use. 3. Changes can be time-consuming depending on the complexity of the update. 4. Retroactive rate changes are the most common. 5. The level of automation brings high value to the stakeholders.	**2**	1. Business users continue to complete mass adjustments using PROMISe™. 2. Changes are more easily processed due to increased automation. 3. Retroactive rate changes continue to be the most common but there is an introduction of proactive rate changes. 4. Retro rate process is consistent across all claim types. 5. This process falls under workflow, and also rules engine has been integrated into this rate setting and adjustment process.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
OM07 Process Claim	1	1. The vast majority of claims are submitted electronically using X12 national standard formats. 2. The processes are centralized to achieve economies of scale. 3. The majority of claims are priced automatically, though some manual pricing continues. 4. Complex edit logic is manually coded. 5. The system edits are lacking in flexibility and costly to change. 6. Data is scanned or keyed in for some claims related to service limitations. 7. Suspended claims require manual review and lengthy resolution. 8. There are delays introduced by manual intervention that negatively impact the stakeholder value however this impact is somewhat offset by the accuracy of the process.	**2**	1. Complex edit logic is both manually and automatically coded. Edit logic utilizes a separate rules engine and is more flexible. 2. A payer-to-payer COB process has been implemented. 3. HIPAA and internal data standards are implemented. 4. NPI is the identification (ID) of record for both claims and encounters. 5. Process steps are a mix of automated and manual. 6. Claims are priced automatically with very few manual exceptions. 7. The process time take 24 hours or less and occurs multiple times per week. 8. The process time is completed within 24 hours to 30 seconds. 9. The ability to easily change system edit logic using a rules engine improves stakeholder satisfaction.
OM14 Generate Remittance Advice	**1**	1. The process is highly automated and accurate. 2. The 835 transaction is currently used for electronic remittance advice (ERA). 3. Some Providers choose the paper RA rather than accept and use the HIPAA standard transactions. 4. Address information accuracy is challenging and can result in returned mail. 5. The high volume of paper RAs negatively affects Commonwealth stakeholder's satisfaction.	**2**	1. The process remains highly automated. 2. Paper RAs have become the exception to a primarily automated and electronic process. 3. Implement a real-time interface with the USPS to eliminate address errors. 4. Commonwealth stakeholder satisfaction is higher as a result of the reduction in paper RA.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
OM18 Inquire Payment Status	**2**	1. The X12 277 transaction is used to acknowledge paid encounters. 2. Phone inquiries are the primary communication channel for FFS providers. 3. Staff researches the MMIS and provides responses to phone inquiries. 4. Standard response protocol is used, but manual processing can challenge consistency.	**2**	1. The X12 276/277 transactions have been fully implemented. 2. The automation of the process reduces the number of phone inquiries. 3. The automation of responses improves the consistency and accuracy. 4. The payment inquiry process is available through the web portal.
OM20 Calculate Spend Down Amount	**1**	1. Cases are managed in CIS using manual review of documentation. 2. Paper and manual processing is common. 3. Some manual intervention is required to resolve PROMISe™/CIS interface issues. 4. Automation of the tracking of cost share payments is minimal.	**2**	1. Cases continue to be managed in CIS with access available to all process stakeholders. 2. Process is a mix of automated and manual steps. 3. Automatic interfaces across applicable systems. 4. The workflow management system includes ticklers, alerts, and dashboard views to enhance case worker follow-up on six month reviews. 5. Eligibility is automatically closed after the pre-determined timeframe.
OM27 Prepare Provider Payment	**1**	1. Home and Community Based Services (HCBS) payments are made using the MMIS adjudication and payment cycle. 2. Manual pricing may still occur. 3. The automation and timeliness of payments has improved stakeholder satisfaction.	**2**	1. The process is a mix of automated and manual process steps. 2. Internal and HIPAA data standards have been implemented. 3. All waiver programs are now processed through the MMIS. 4. The automation has led to improvements. 5. As a result of the improvements, additional service providers have joined the program.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
OM28 Manage Data	**1**	1. The process is a mix of manual and automated tasks. 2. The manual processes typically involve writing and executing multiple queries. 3. Multiple tools and data stores are used to manage program information which can impact effort and efficiency.	**2**	1. The automation of processes improves the timeliness and accuracy of the results. 2. There is an increased use of industry standards in the process. 3. Financial reporting capabilities have been improved.
OM29 Process Encounter	**1**	1. Process is highly automated. 2. Only a few suspended claims against encounters require manual intervention. 3. The encounters are processed through the MMIS (PROMISe™). 4. PROMISe™ may continue processing encounters even though the recipient file is unavailable. This results in encounters being processed and sent to downstream files without valid recipient data. 5. New and changed edits intended only for FFS claims are sometimes implemented for encounters.	**2**	1. The process verifies access to the recipient file during processing and prevents incorrect processing. 2. Edits logic differentiates between FFS claims and encounter data preventing incorrect denials. 3. The reduction of processing errors has improved accuracy and stakeholder satisfaction.
OM30 Manage Drug Rebate Dispute Resolution	**1**	1. Process is heavily reliant on paper documentation. 2. Process is manual. 3. Process is hindered manual and non-standard interaction with manufacturers. 4. The effectiveness of the process leads to a continued positive working relationship with the labelers.	**2**	1. Process utilizes a mix of paper/phone/fax and electronic data (ED). 2. Process is a mix of manual and automated process steps. 3. Improvements in automation have improved stakeholder satisfaction. 4. The process now includes all FFS and MCO encounter data. 5. The MMIS is connected to the HIE/EHR system to improve data accuracy.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
OM31 Manage Payment of Non-Emergency Transportation	**1**	1. The process is labor intensive. 2. The data is manually supplied by the county, can be inaccurate and/or incomplete, and is not easily accessible. 3. Process relies on manual process and analysis. 4. Process uses paper invoices and manual payments. 5. Data accuracy varies significantly by county. 6. Stakeholder satisfaction is low due to the labor intensive process.	**2**	1. Process is a mix of automated and manual process steps. 2. A mix of electronic and paper invoices are generated. 3. Payments are mostly EFT with few paper exceptions. 4. Stakeholder satisfaction is tracked and measured.

3.6 Business Relationship Management

3.6.1 Overview

The Business Relationship Management business area is currently represented in many states as a component of Contractor Management. Most MMIS and related systems are not able to support the full data exchange as envisioned by MITA. While this Business Area is similar to Contract Management, the collaboration between internal (e.g., other Pennsylvania Departments/Bureaus), intrastate (e.g., HIE), and external (e.g., CMS) entities is increasing in importance. HIPAA provided an introduction to Business Relationship Management through the concept of business associate agreements.

MITA's vision for Business Relationship Management in Pennsylvania is that it supports standards-driven, automated data exchange throughout the PME and with external entities for which there is a contractual or business relationship. Business Relationship Management owns the standards for interoperability between the PME and its partners. The current definitions of these processes do not yet address national standards. The MITA Framework is likely to undergo significant refinement as data exchanges between the various state Medicaid Enterprises develop.

3.6.2 Business Relationship Management As Is Summary

Pennsylvania currently enters into agreements through the establishment of contracts and MOUs where the details and methods for extracting and exchanging data are defined. This manual process lacks processing standards, standard agreements, and standard data formats resulting in inconsistent, inaccurate, and inefficient data exchanges. Consensus concerning the definition of privacy and security requirements between entities slows the process completion time. The majority of effort in business relationship management is manually maintaining current agreements with many entities, each having a uniquely defined (silo) data exchange format.

Numerous programs and business units within the Medicaid Enterprise perform or have a role in managing business relationships. These include but are not limited to:

- DPW
  - OA
    - BIS
  - ODP
  - OGC
  - OIM
  - OLA
  - OMAP
    - BDCM
    - BMCO
    - BPAP
  - OMHSAS
  - OPD
- HPES

Review of the Medicaid Enterprise indicates all Business Relationship Management business processes currently are determined a Level 1.

The primary factors affecting maturity ratings across the Business Relationship Management Business Area include the following:

- All four business processes are mix of manual and automated steps
- Case complexity affects all aspects of the business area
- Data is primarily obtained manually, maintained electronically, and data validation is manual
- Documentation and MOUs are stored in non-standardized, disparate locations and are not easily accessible
- Approvals and bureaucratic intervention causes the process to be untimely
- MOU forms and documents are not standardized across programs and projects
- Data accuracy relies on manual efforts due to a lack of automation
- Updates to documentation occur manually via email and phone calls
- There is time-intensive document collaboration between the different programs for validation and approvals
- Communication formats are mostly manual and not standardized
- The process is inconsistent, difficult, and lacks standards which contribute to low stakeholder satisfaction

3.6.3 Business Relationship Management To Be Summary

As established during the Commonwealth's EVS, this business area is considered a low priority for capability improvements. As a result, the resources dedicated to improvements to this area will be made available once higher priority areas such as Member Management and Care Management have been addressed. The Commonwealth will focus on making improvements to sharing data, consolidating redundant systems, promoting self-service for its business partners, and managing stakeholder satisfaction.

The Pennsylvania goals for Business Relationship Management as determined during the EVS are as follows:

- Develop integrated workflow to achieve maximum resource utilization
- Increase community collaboration and improve the ability to exchange information consistently by enforcing data exchange and Service Level Agreements (SLAs) between Pennsylvania programs, providers, and contractors
- Improve contract administration through centralized data and standard processes
- Improve translation services and resources
- Develop common patient medical record data, e.g., track patients from FFS to managed care and coordinate between behavioral health and medical health

Additional functional capability improvements for Business Relationship Management include the following:

Business Relationship Web-Based Portal:

- Must support collaborative development of MOUs and documentation including ability to check-in, check-out, and maintain user history
- Incorporate functionality that supports workflow, routing, triggers and alerts, and performance metrics
- Functionality must include the ability to move forward or backwards in the process
- Additional functionality must include the ability to save work in progress, utilize existing templates to transfer and modify, and provide historic repository of previous and existing MOUs
- Functionality must support the document of record concept where amendments and updates are automatically incorporated in the master copy
- Functionality must include a searchable library of optical character recognition (OCR) MOUs, interfaces, and data dictionary and copy book for each exchange. This will be used over time to consolidate the data model and reduce the number of extracts.
- Functionality must support full audit and tracking capabilities including query and report capabilities
- Functionality must include user configurable dashboard capability to actively monitor activity such as data file exchanges, file size, file volume, access attempts, usage levels, exception errors, user reports, and time-driven metrics
- Functionality must include the ability to stop the data share process when an agreement has expired
- Functionality must support termination reason, lessons learned, and other descriptive text in a memo or other field
- Extend portal access to trading partners to allow self-maintenance of information and to review reports
- Account driven user logons
- System must support termination checklist including data requirements and transfer requirements
- Functionality must ensure data integrity and guard against breaches. Communication security must be considered during system development, data exchange agreement, and the exchange. As a result, any automated system enforcement must be considered.
- System must support enhanced help capabilities for each screen. This functionality will support the training of new staff, help to answer questions, and reduce processing time.

Data Use Agreements:

- Data use agreements will need to be put in use between states, federal, and commercial partners to improve recovery processes
- Establish data use agreements with other stakeholders involved in the Prepare COB process

Other:

- The MOU process should promote self-service and real-time data exchanges
- Paper communication documents should be the exception and must be OCR scanned and have the ability to associate with the CRM record
- Formal protocols for communication and routing must be developed for all MOU communications
- Routing must be automated and must support escalation of issues
- Incorporate functionality that allows user configurable business rules to support MOU development
- These business rules should include recommended line items, best practices, and a checklist of required information
- Integrate enterprise system or data model changes to the MOU library
- Implement a standard data model to support standard MOU language

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 9: Business Relationship Management Maturity Level

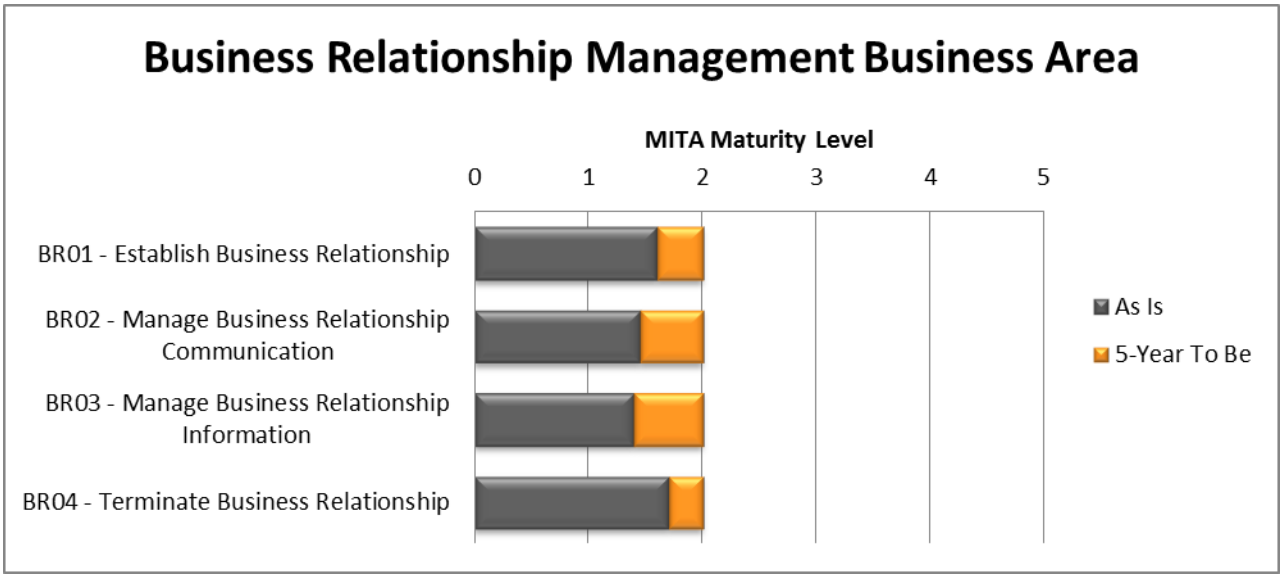


Table 7: Business Relationship Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
BR01 Establish Business Relationship	**1**	1. There are some formalized contract terms for exchanging data. 2. The involvement of multiple stakeholders allows for accurate process results which benefits all the stakeholders. 3. Process is primarily manual. It can involve	**2**	1. The process has been standardized with a formal process and consistent contract terms. 2. Commonwealth standards have been established. 3. Improvements in automation have improved the efficiency, timeliness, and cost effectiveness of the process. 4. An integrated workflow has been developed to achieve maximum resource utilization.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		case-specific data exchange protocols (e.g., frequency, file layout, approvals). 4. Dialogue with potential partners is the primary source for gathering data used to establish relationships. Other data used to establish relationships is available electronically. 5. The cost-effectiveness will vary from case to case based on the complexity of the business relationship being established.		5. Contract administration uses centralized data and standard processes. 6. Translation services and resources have been improved. 7. Process time is 2 weeks or less. 8. Process is a mix of automated and manual tasks. 9. Efficiency increases in management of business relationship agreements due to automation of data storage and use of data standards. 10. The process meets HIPAA privacy and security guidelines. 11. Stakeholder satisfaction is tracked and measured.
BR02 Manage Business Relationship Communication	**1**	1. The process is well defined and works well when necessary to terminate contracts. 2. Process results have been historically accurate. 3. Given most notification the process requires up to 30 days' notice prior to termination. 4. Information is virtually always received and transmitted electronically. Manual analysis is required in most cases. Approvals and bureaucratic intervention causes the process to be untimely. 5. Data is easily accessible and accurate. 6. Effort and efficiency can vary depending on the nature of the communication, the complexity of the business relationship and the business area managing the communication. The process is not standardized or centralized making efficiency difficult to determine.	**2**	1. Integrated workflow process has been developed to achieve maximum resource utilization. 2. Contract administration improved through centralized data and standard processes. 3. Automation and standardization provides clear and useful information. 4. Process timeliness improves through use of automation. Timeliness exceeds legal requirements. Process completes, on the average, in no more than 10 business days. 5. The process is primarily manual with few manual exceptions. 6. Medicaid enterprise increases number of communications through the use of technology while reducing per unit cost. 7. The process is both standardized and centralized.
BR03	**1**	1. Data exchange	**2**	1. An integrated workflow has been

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
Manage Business Relationship Information		standards have been upgraded to the American National Standards Institute (ANSI) X12 5010 versions. 2. Information is virtually always received and transmitted electronically. 3. The average time to manage the relationship ranges from several hours to several weeks. 4. Process is a mix of manual and automated steps. Data is sent electronically, but protocols and data validation are manual. 5. Internet and intranet are used but may require paper distribution. The vast majority of MA bulletins are still distributed through the mail hardcopy. 6. There is no central repository for MOUs. 7. Accuracy, efficiency, and cost-effectiveness of the process results depend on the clarity of the requested updates to the relationship. 8. Stakeholder satisfaction is not being tracked and/or measured.		developed to achieve maximum resource utilization. 2. The average process time to manage the business relationship ranges from several hours to 2 weeks. 3. Automation has improved the timeliness of the process. 4. Process is a mix of automated and manual process steps. 5. The process often has online access to data. 6. The Medicaid enterprise has a standard process for communications 7. Medicaid enterprise increases number of communications through the use of technology while reducing per unit cost. 8. Business partners receive timely, accurate, and useful information. 9. Use of HIPAA data standards. 10. Stakeholder satisfaction is being tracked and measured. 11. Communication is functionally, linguistically, culturally, and competency appropriate
BR04 Terminate Business Relationship	**1**	1. Efficiency varies from relationship to relationship. 2. There is no central repository for MOUs. 3. Accuracy of the process results depends on the clarity of the requested updates to the relationship. 4. It is very difficult to process updates in a timely fashion.	**2**	1. Automation and Commonwealth standards increase productivity. 2. Implementation of local standards and the centralized tracking of the data increase the ability to terminate the business relationship. 3. Stakeholder satisfaction is being tracked and measured.

3.7 Contractor Management

3.7.1 Overview

The Contractor Management business area accommodates states that have managed care contracts or a variety of outsourced contracts. Some states may, for example, group provider and contractor in one business area. The Contractor Management business area in PME has a common focus (e.g., manage outsourced contracts), owns and uses a specific set of data (e.g., information about the contractor or the contract), and uses business processes that have a common purpose (e.g., solicitation, procurement, award, monitoring, management, and closeout of a variety of contract types).

Creating a separate business area for Contractor Management allows the MITA process to highlight this part of the PME, which is becoming increasingly important to state Medicaid agencies. Indeed, it is the primary focus in Pennsylvania to have comprehensive managed care or multiple-contractor operations. In the Contractor Management business area, the many types of healthcare service delivery contracts (e.g., managed care, at-risk mental health or dental care, primary care physician) and the many types of administrative services (e.g., FA, enrollment broker, Surveillance and Utilization Review (SUR) staff, and third-party recovery) are treated as single business processes because the business process activities are the same, even though the input and output data and the business rules may differ.

3.7.2 Contractor Management AS IS Summary

Numerous programs and business units within the Medicaid Enterprise perform or have a role in managing providers. These include but are not limited to:

- Department of General Services (DGS)
- DOH
- Department of Labor and Industry (DLI)
- DMVA
- DPW
  - OA
  - OB
  - OCDEL
  - ODP
  - OGC
  - OIM
  - OLA
  - OLTL
  - OMAP
  - OMHSAS
  - OPD
- Governor’s Office of Administration
- OAG
- OIG
- OLRM
- PDA
- PDE
- PID
- U.S. Department of the Treasury
  - Office of Comptroller

Currently in Pennsylvania, numerous programs produce an RFP every two to eight years depending on contract terms. In addition, clinical criteria must be integrated and managed by several vendors and are updated through policy changes. Depending on the complexity of an RFP, the receipt, evaluation, and award of a contract can vary greatly with the program office involved and the amount of pre-selection negotiations that are done and updated through policy changes. The contract or management data is maintained across multiple systems using Microsoft Office Tools, PROMISe™, CIS, SAP, and Supplier Relationship Management (SRM).

The management and award, inquiry, support, communication, and close out of contracts are primarily manual. Paper documentation forms are mailed and often used as a method of sending supporting documentation for review. Generally when a contract ends, Pennsylvania manually creates a checkout template that includes everything that deals with the contract.

Review of the Medicaid Enterprise indicates all Contractor Management business processes currently are determined a MML 1.

The primary factors affecting maturity ratings across the Contractor Management Business Area include the following:

- All nine business processes are conducted manually with a mix of improved communication mechanisms such as electronic media or web portal
- Data exchanges are conducted manually, electronically maintained, and data is distributed by electronic media or web portal
- Pennsylvania uses web portals, email distribution, and tracking for respondent communications
- Contracts are stored in disparate locations and data is inconsistent across programs
- Data accuracy relies on manual efforts due to a lack of automation
- Updates to documentation are conducted manually via email and document collaboration between the different programs
- Communication formats are mostly manual and not standardized
- Stakeholder satisfaction is not being measured

3.7.3 Contract Management To Be Summary

As established during the Commonwealth's EVS, this business area is considered a low priority for capability improvements. As a result, the resources dedicated to improvements to this area will be made available once higher priority areas such as Member Management and Provider Management have been addressed. The Commonwealth will focus on making improvements to sharing data, consolidating redundant systems, promoting self-service for its business partners, and managing stakeholder satisfaction.

The Pennsylvania goals for Contractor Management, as determined by the Executive Leadership are:

- Interface with the administration system for Contract tracking and management
- Improve and automate the ability to monitor a contractor's performance in meeting financial, program outcomes, compliance, and client service and satisfaction goals, and to leverage this information in making contractor payments based on performance
- Reduce duplication of effort (e.g., regulatory vs. contract monitoring)
- Streamline administrative burdens. Improve and automate all phases of the contract management process through implementation of automated workflow management
- Centralize all contract management and make it available throughout the Medicaid Enterprise and subsequently the entire Commonwealth

Additional primary functional capability improvements across the Contractor Management area include the following:

Governance/Policy:

- The architecture will need to focus on the contract as a central object supporting the various business functions in an efficient manner
- The Contractor portal must be account driven and roles to be extended to a contractor post award. It will allow for integration of eMarketplace, procurement library, Pennsylvania network resources, Treasury, DocuShare, SAPs and others, and will require stakeholder participation, access, and planning.
- Publishing of appropriate information for public consumption. This will include consideration for business rules, content types, and update management.
- Enforcement and loading of communication plans for all contractors. Plan must include a standard set of communication vehicles based on communication type.
- Take advantage of external resources for integration, including state and federal regulations (e.g., gpo.access.gov)
- Review of statutory requirements and policy to ensure the support of fully electronic RFP review and evaluation
- Role-based access, which would include the vendor community, to allow for contract monitoring documentation
- Include a MITA To Be roadmap project to establish a MITA governance group
- Ensure governance for Contractor Management includes the agencies specified

RFP Focus:

- Standard set of SLAs, metrics, deliverables, and work plans must be included in standard RFP language
- Include standard contract closeout language in all RFPs including metrics, run out dates, and transition requirements
- Expand current electronic Request for Proposal (eRFP) capabilities

Workflow:

- Communication capabilities including automated triggers and notifications for upcoming contract events. This must support the ability to target and to add multiple email addresses for alerts.
- Workflow should include supporting the hearings process and capturing and routing appropriate material, in addition to including links to appropriate state statutes, federal regulations, other requirements, and law libraries
- Business process reengineering in which the workflow is redefined
- Expand access to outside users, such as CMS, to review documents at appropriate points in the workflow
- Standard mandatory performance reviews for the end of each contract. This would be included in an online survey that essentially becomes a part of that procurement.
- An interactive, business-oriented project flow in development of the RFP and centralizing the RFP itself as an object

System Functionality:

- Enhance CRM to manage all aspects of the contract in a single web-enabled tool, including day-to-day operations, metrics, cost and invoicing, change orders, updates, document of record, performance measurements, and SLAs

- Standard tool to implement, manage, provide dashboard reporting, and generate standard reports. Document of record concept will support an interactive, auto update master copy which contains all updates and amendments with a full audit trail of changes including date, time, user, and change.
- For prospective contractor outreach, functionality must include the ability to track outreach materials and events for effectiveness and analysis. The project management dashboard must include the ability to recognize dates and automatically notify managers when tasks are completed or status has changed.
- The ability to build cases using automated report generation, document retrieval, date span retrieval, and searches by contractor, sender, and subject line
- Business cases such as right-to-know requests must be supported through query and reporting capabilities

Data Management:

- With the capability to load all associated documentation to a new RFP project, including pre-population of key information, the system will have the means for wizard functionality to recognize user rules for contract closeout, transition, and renewal and extension considerations, inventory lists, staff support requirements, and other aspects
- The automated evaluation process must be a module within the workflow management system, keeping track of all artifacts and processes such as scoring the proposals, questions, and responses from vendors, best and final offers (BAFOs), negotiations, and tracking and management of the evaluation team and their scores associated with the proposal
- Make history of vendor performance information available for prospective contracts

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 10: Contractor Management Maturity Level

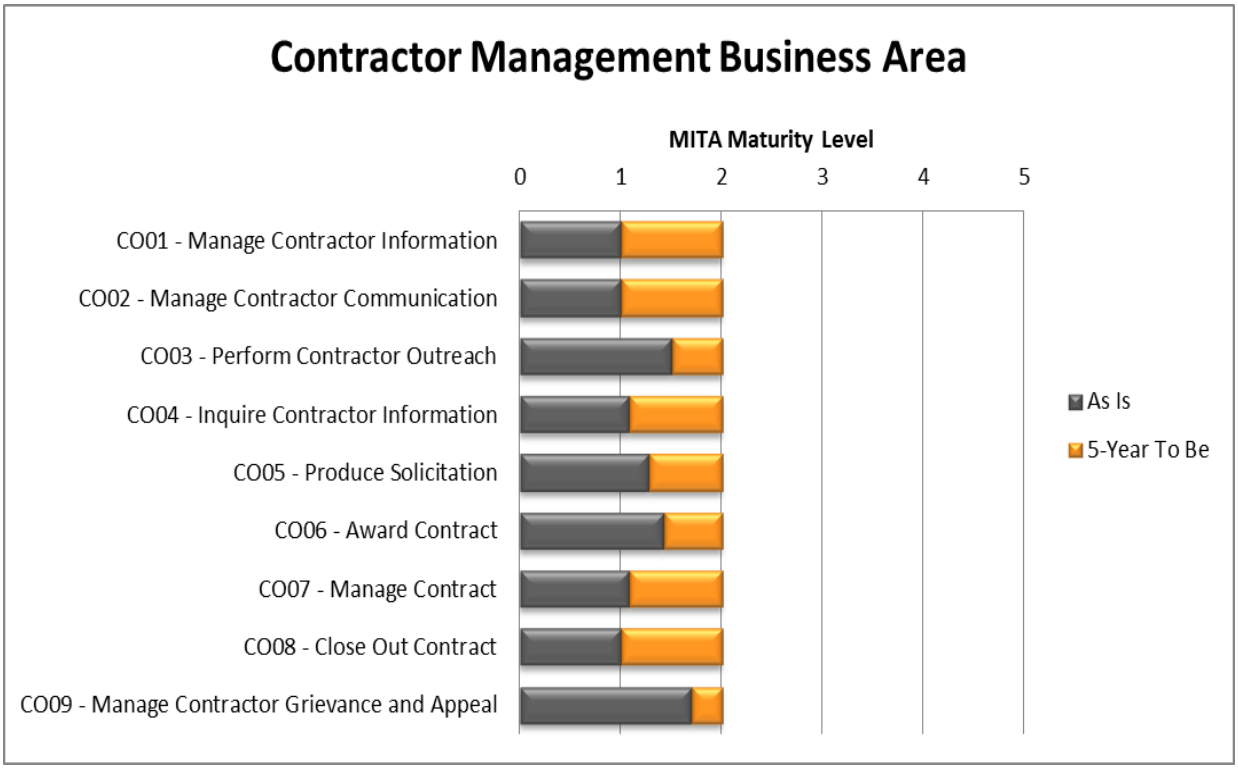


Table 8: Contractor Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
CO01 Manage Contractor Information	**1**	1. Staff receives instructions to update the contractor master file from many sources via paper and fax. Validation is manual and subjective. 2. Maintenance of contract files, contract amendments, and related documents is a manual process. Timeliness is dependent upon the business area and individual managing the contract. 3. Contractor information is contained in written documents. Information maintenance requires manual processes affect data accuracy. 4. Contractor information is maintained in manual files. Accuracy is difficult to determine. 5. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.	**2**	1. Requests are locally standardized and automated. Validation is consistent and rules-based. State and Federal standards are used. 2. Contracts, amendments, and related documents are scanned and stored. Timeliness is increased over Level 1. 3. ED sources increase the ability to access data and the accuracy and consistency of the information over that at Level 1. 4. Contractor information is stored electronically. Accuracy of results is improved over Level 1. 5. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements.
CO02 Manage Contractor Communication	**1**	1. Communication is primarily conducted via paper, fax, and phone. Communications are uncoordinated among multiple, siloed programs without systematic triggers. 2. Standards for these communications do not exist or are not in place. 3. Staff log and manually research requests, which may take several working days. Timeliness is often driven by factors such as legal and statutory restrictions. The process is meeting the needs within the silos; however, the process is not considered to be timely when multiple programs or cross organizational coordination is required. 4. Staff manually researches policy manuals, contracts, and other documents. Data access and accuracy can be	**2**	1. Increased use of electronic methods. The PME accepts inquiries that can be responded to online or by phone. Communications are centralized via websites to provide contractor information. 2. Standards are developed for common online queries. A formal Communications Management Plan has been established following Project Management guidelines. 3. Contractors access Help services via a portal. Many common inquiries are answered online. Most requests can be answered in 24 hours or less. 4. Automated responses improve ease of access. The process is able to receive and send communications more efficiently. 5. Formal process uses some automation to ensure that all legal and contractual requirements are met.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		hindered or compromised. 5. Process results are minimally accurate; most legal and contractual requirements are met. 6. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		6. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements.
CO03 Perform Contractor Outreach	**1**	1. The process is primarily conducted by mail and telephone for individual communications; flyers, radio, TV, newspapers, and publications that post contractor RFPs. 2. Outreach is uncoordinated among multiple, siloed programs; lacks data to appropriately target populations. 3. The process is informal and inconsistent. 4. The needs of the program offices are anticipated and identified in order to perform timely contractor outreach. Monitoring tools (such as dashboard) are used to track future needs. Monthly meetings are held with program offices for strategic planning. Complexity and stakeholder involvement can slow the process. 5. The data gathered for use in this process is primarily a manual effort utilizing networking, websites, vendor solicitations, and conferences to identify and target potential contractors. 6. Information for the outreach is manually accessed. This adds to the time requirements for this process. 7. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.	**2**	1. The process is conducted via an Internet portal for existing contractors and by newspapers, publications, and online advertising services that post contractor RFPs. 2. Outreach is better coordinated because programs are able to share analysis/ performance measures based on increased standardization. 3. The process is formal across the PME with proper reviews to ensure correctness and legality. Accurate logs are kept of all outreach initiatives. 4. Timeliness is improved due to electronic modes of dissemination. Outreach activity requires less time than at Level 1. 5. Increased use of electronic communications which have built-in verifications of accuracy. 6. Some information for the process is accessible electronically. This reduces the time requirements for launching the outreach. 7. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements.
CO04 Inquire Contractor	**1**	1. This is a manual process. The process varies across program areas; however	**2**	1. The Commonwealth provides portals for inquiries and responses. Inquirers have

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
Information		typically the inquirer contacts the Agency by telephone, fax, or USPS and receives responses via the same modes. 2. Although there are no standards and no central repository exists, current information is made available. 3. Unless inquiries come into the DPW Secretary Office, contractor inquiries are generally not routed to a central location. 4. The process is not documented and therefore not consistently repeatable. 5. Inquiries are answered within several working days. 6. Responders must consult paper files. Access to information is limited to business hours. 7. The manual process results in low efficiency, meeting minimal agency performance guidelines. 8. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		access under the mandatory requirements for access to public information regarding the Contractor/Contract. 2. Each department has its own standards for the inquiry and response. 3. Inquiries are framed by the profiles available on the portal. The profile includes contractor name, address, start and end date, major services provided and contact information. 4. The process is formal across Commonwealth agencies with proper reviews to ensure correctness and legality. Accurate logs are kept of all inquiries. 5. Responses are available immediately via the portal. 6. The portal is accessible according to its scheduled availability. 7. The portal solution meets agency performance guidelines introducing more efficiency. 8. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements.
C005 Produce Contractor Solicitation	**1**	1. The process is primarily manual and is reinvented each time an RFP is deemed necessary. A few automated steps exist. 2. Data exchange is conducted manually using email and phone communication. Manual compilation of data is required. 3. Access to data is limited by constraints of the manual process and updates to information. Accessing information to research/compile RFP content can take more than 6 months. 4. Data access and accuracy is dependent on the program office involved, resource experience and the	**2**	1. The process is more automated, centralized, and coordinated between agencies. Manual compilation of data remains a requirement in some cases. 2. Publication of the RFP and communication concerning updates and RFP status with potential respondents are automated. 3. Contract data is more centralized and there is coordination between agencies. Medicaid specific policies and procedures are implemented. 4. Local standards for RFP content are used. The development of Medicaid specific policies and procedures for the RFP process reduces confusion and provides more accurate data within the RFP. Shared electronic work

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		availability of historical data required to produce the RFP. Pockets of excellence within some program areas currently exist. 5. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		space and version control improve efficiency of this process. 5. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements.
CO06 Award Contract	**1**	1. The Award Contract process is manual. The paper proposals are mailed to the Agency. Manual validation, verification, and assessment of proposal data are required. 2. External management of the evaluation and selection process ensures the accuracy of process results. Additional oversight is required to ensure compliance with state and federal procurement rules. 3. The process complies with state and federal regulations however, overall the process is not cost effective due to inconsistencies in the contract approval routing process. 4. Accessing information to verify, validate, and assess proposal data is challenging due to data being stored in disparate locations and manual recovery processes are necessary. 5. Manual processes allow gaps in the accuracy and completeness of proposal content. 6. Timeliness varies by program office, complexity, approvals required, and executive sponsorship. The timeliness is also dependent on the experience and skills of resources evaluating, negotiating, and recommending the award of the contract. 7. Pennsylvania does not monitor and/or solicit satisfaction from	**2**	1. Submission of proposals is via electronic medium. Centrally accessible electronic storage of proposal materials and internal electronic communication has been implemented. Assessment of proposal data is manual. 2. Introduction of standards and automation further reduce opportunity for error and level of oversight required. 3. Commonwealth-defined data and content standards are implemented. Centralization reduces process costs and allows staff to shift some attention to cost management and ongoing quality improvement. 4. Increased standardization by the Commonwealth procurement office, increased use of electronic storage of proposal materials, and electronic communication mechanisms simplify data access. 5. Automation and implementation of standards increases accuracy. 6. Centrally accessible electronic storage of proposal materials and internal electronic communication reduces total work effort within the agency. 7. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		stakeholders as described for this business process.		
CO07 Manage Contract	**1**	1. Contract management is not centralized. Oversight of the management of a contract lies with the agency who requested the contract. There is little or no coordination among agency programs for procurement or management of contracts. 2. The contract management process consists primarily of manual, paper based steps, although it varies depending on the contract. 3. Timeliness of monitoring is dependent upon the program involved and resource experience. Timeliness of changes and contract amendments varies depending upon the approvals that may be required and executive sponsorship when exceeding established thresholds. 4. Efficiency is dependent upon the program involved, resource allocation and experience, and the availability of data required to monitor, amend, or change the contract. Efficiency is impacted by executive sponsorship and adherence to departmental standards. 5. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.	**2**	1. Centralized tracking of contracts is implemented. Coordination between agencies reduces silos and increases efficiency in contract management. Coordination among agency programs for procurement or management of contracts is improved. 2. Contract information is stored electronically. Contract management reports are also automated. 3. Centralization of contract and use of local standards for data format and content reduce end to end time. Obtaining information to monitor or review contract and interactions with contractors require less time than at Level 1. 4. Centralization of contract information and introduction of standards increases efficiency over Level 1. Automation decreases duplication of effort across the agency. 5. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements.
CO08 Close Out Contract	**1**	1. There is no centralized oversight of the contract close out within the Medicaid Enterprise. There is no coordination among Commonwealth programs or between the Commonwealth Medicaid Agency and other Commonwealth agencies in relation to closing out contracts. 2. The close out contract process consists primarily of	**2**	1. PME centralized tracking of contracts is introduced and implemented. Policies have been introduced to oversee the close out process, and coordinate efforts between agency programs. 2. The process uses electronic storage of contract information and internal electronic communications. 3. Mixed automation and manual contract close-out processes can

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		manual, paper-based steps. 3. The fully manual contract close-out process can exceed 3 months or more depending on contract requirements. 4. Data access and accuracy is dependent upon the program involved, complexity of the contract, and resource experience. The manual nature of the process causes delays in information retrieval. Information in offsite storage may take up to 2 weeks to retrieve. 5. The primarily manual contract close-out process is often inefficient and results in disputes and delays in resolution. Efficiency is impacted by adherence to guidelines imposed by external agencies. 6. Lack of data accuracy and completeness, process integration, and manual processing adversely affect the quality, consistency, and accuracy of the contract close-out process. Excessive manual oversight is required to ensure accuracy. 7. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		be completed in significantly less time than Level 1. 4. Implementation of data, format, and interface standards and centralized contract close-out data simplify data access. Information retrieval takes significantly less time than Level 1. 5. Efficiency increases with automation, centralized tracking of contracts, coordination among agency programs, and interface data exchange standards. Staff is able to follow consistent steps in the close-out process. 6. Implementation of local data, format, and interface standards and the centralized tracking of the contracts simplify data access, increasing the quality and consistency of the contract close-out process. 7. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements.
CO09 Manage Contractor Grievance and Appeal	**1**	1. The process is entirely paper based, which results in cumbersome document management and process inefficiencies. The process can be labor intensive to perform. 2. There is a centralized location for information (contractual data, grievance information, and history). 3. The contracts are housed in the Procurement Office; however, additional information on the contract is housed in the program offices. This results in	**2**	1. The process conducts some of its activities electronically, except where paper documents are required by law. In this case, the documents are scanned for ED capture. 2. Agencies begin to centralize or standardize the administration of this process to achieve economies of scale, thereby increasing coordination and improving consistency by which rules are applied and appeals disposed. 3. The process is clearly identified. A Review Board has been established to review cases.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		potential problems with access. 4. The process is governed by statute which includes timeframes. Timeframes are consistently met; however, there is a provision to extend the timeframes if needed. Contract controversies are also completed in a timely manner. 5. The results are as accurate as the effectiveness of the discovery done during the process. Formal process is in place ensuring that all legal and program requirements are satisfied. 6. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		4. Increased automation to manage case files and capture information reduces process time as compared to Level 1. 5. Changes support business activity monitoring of performance measures, which in turn provide accurate data needed for process improvements. 6. Pennsylvania will implement a portal that supports stakeholder interaction and allows for strategically managing improvements. Average cases are resolved in a shorter period of time that at Level 1.

3.8 Provider Management

3.8.1 Overview

The Provider Management business area is a collection of business processes involved in communications between the PMA 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.

3.8.2 Provider Management As Is Summary

The Commonwealth of Pennsylvania has numerous programs and business units within the Medicaid Enterprise that perform or have a role in Provider Management. The offices follow work management processes and use PROMISe™, which houses specific provider information and interfaces with various databases to manage the business processes. Business units within the Enterprise that have ownership in Provider Management include but are not limited to:

- DOH
- DMVA
- DPW
  - OA
  - OCDEL
  - OCYF
  - ODP
  - OLTL

- OMAP
  - BDCM
  - BFFSP
  - BMCO
  - BPAP
- OMHSAS
- PDA

Review of the PME indicates the Provider Management business processes are currently at a MITA Business Capability Maturity Level 1. The primary factors affecting maturity ratings across the Provider Management business area include the following:

- Due to the manual nature the business processes, large numbers of staff are required
- Timeliness, efficiency, accuracy, and cost effectiveness are impacted by the manual processes
- Data exchanges are conducted manually between stakeholders
- Communication formats and outreach efforts follow standard protocols, but due to the detail and customization of requests from multiple provider types in different programs, they are rarely standard in format or content
- There is no consistent analysis of outreach and education effectiveness
- Provider grievances business processes are not standardized and little collaboration between entities occur, however appeals are standardized
- Stakeholder satisfaction is not actively measured aside from provider feedback collected at public meetings and ad hoc, unsolicited

3.8.3 Provider Management To Be Summary

As established during the Commonwealth's EVS, and as a result of the upcoming implementation of the ACA, this business area is considered a high priority. This business area will advance in Maturity Level as system changes and enhancements relevant to the ACA are implemented.

The Commonwealth will focus on ACA compliance, using a model and approach that complies with 7C&S. Focusing on modularity, the Commonwealth will leverage the existing PROMISe™ system to accommodate the required upgrades.

The goals for Provider Management are:

- Enhance the use of automated, clinical messaging throughout the Medicaid Enterprise
- Enhance the MPI and promote its usage throughout the Medicaid Enterprise
- Enhance the MPI to include the ability to geographically assess the provider network
- Develop uniform, automated screening, and credentialing for all health care providers
- Improve the ability to effectively and efficiently communicate with providers
- MAPIR – Ongoing collaboration with multiple states to promote meaningful use
- Eliminate barriers to improvements, e.g. requiring providers to submit paper forms due to a Commonwealth regulation requiring "handwritten" signatures

The To Be sessions revealed additional capabilities needed for Provider Management. Listed below are the key projects for improvements that the SMEs felt would help move one or more of the Provider Management business processes to the next MML.

Enhancement of Provider Repository (PR):

- Enhance the PR to handle all types of providers (typical, atypical, and Pennsylvania-defined)
- Meet broader definitions of a provider and provide web-enabled access for all programs and regions

- Support the data needs for all programs, including the implementation of business intelligence to organize and present information at the point of need and upgrade address functionality in the repository to minimize return mail

Centralized Processes:

- Implement One-Stop Provider Enrollment, Screening, Credentialing, and Re-enrollment/Re-credentialing that are integrated with PME web-based applications and data sources to propagate data and support active data monitoring and analysis to proactively identify anomalies

Enhance Business Process Automation:

- Implement functionality that is user configurable, automatically disenroll providers based on information received from other integrated data sources, and expand EDW, Fraud and Abuse Detection System (FADS), and other data repositories to meet To Be user needs, and automatically capture and analyze provider data to support regulatory data
- Explore funding and contractual opportunities to utilize and support the Enterprise and assess and expand current commercial and public resources that are analyzing and maintaining provider data
- Enhance the provider portal must be enhanced to ensure it is account driven to post provider unique data

Improve Provider Communications:

- Improve communications to effectively and efficiently communicate with providers, utilizing all available electronic media (e.g., instant message, web forms, and searchable discussions)
- Update policies and communications to promote the use of provider self-service portals, attach hyperlinks, documentation, and interfaces to other resources when necessary to enhance portal use and provide alert and notification functionality
- Implement a comprehensive CRM capability to track and manage provider communications where interactions are both public and private for any entity and CRM is integrated with other provider resources across the enterprise

Other:

- Establish governance for all MITA related improvements
- Capture and analyze the metrics used to make policy change arguments
- Implement an all-payer database and integrate to the MPI

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 11: Provider Management Maturity Level

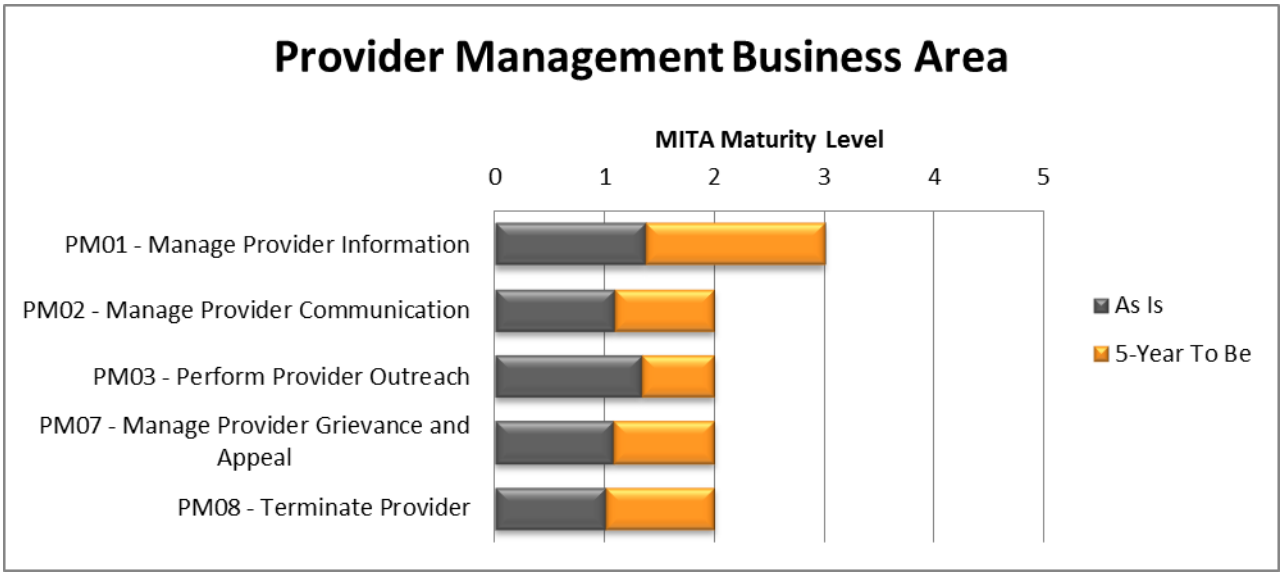


Table 9: Provider Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
PM01 Manage Provider Information	**1**	1. The Commonwealth uses a mix of manual and automated processes. 2. Timeliness, efficiency, and cost effectiveness are impacted by the manual intervention required to complete the process. 3. Accuracy of data is manually verified and susceptible to inconsistent and incorrect information. 4. NPI is used, but is translated to local IDs if needed for internal processing. Atypical providers continue to use proprietary identifiers, unless a national standard has been established. 5. Validation of application information is manual and subjective.	**3**	1. The PMA will automate this business process to the full extent possible within the intrastate. Enhanced background information, screening information, and application fees will be stored and an audit trail which reflects decisions will consistently be produced. 2. Validation of data is automated and business rules engines will be used for consistent validation within the Commonwealth. 3. MITA and other industry standards will be used across the intrastate when exchanging information. 4. The PMA will collaborate with other intrastate agencies to adopt national standards and share reusable business services, thus improving the overall timeliness of the business process. 5. Accessibility to data and accuracy of data will improve through increased automation of

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		6. Manual and semi-automated steps require some days to complete update and maintenance process. 7. The Commonwealth focuses on meeting compliance thresholds using state-specific standards with very little collaboration occurring among agencies. 8. Duplicate entries may go undetected. There are known inaccuracies in the stored data. 9. Staff experiences delays, difficulty in retrieving information, and inaccuracy of information leading to low level of satisfaction.		information collection and exchange. 6. Increased automation and use of national and industry standards greatly increases the cost effectiveness and efficiency of the business process. 7. Staff is generally satisfied with timeliness and accuracy of data stored and access to it. 8. Staff is satisfied with timeliness and accuracy of data stored and access to it. Provider complaints are fewer and seem generally satisfied with timeliness and accuracy of data stored.
PM02 Manage Provider Communication	**1**	1. Manual and automated processes are used to accomplish tasks. 2. Communications are inconsistent in format and content and do not allow for linguistic, cultural, or competency variations in all instances. 3. Most requests for information from providers are sent via telephone, fax, or USPS. Most communications from the agency are sent via USPS. 4. Requests from providers are received in a non-standard format. Responses and unsolicited communications are provided manually in an ad hoc manner or occasionally in a standard format. 5. Pennsylvania does have some systems, like EVS; however, most communications require manual intervention. 6. Responses require 1	**2**	1. The business process is automated to the greatest extent possible within the intrastate, including communication by email, paper, mobile devices, Automated Voice Response System (AVRS), telephone, facsimile, web portal, or EDI transaction. 2. Routine and regular communications are standardized, consistent, and timely. Functionally, linguistically, and culturally appropriate communications are used to a greater extent. 3. The PMA collaborates with other agencies to adopt standard practices and national (e.g., HIPAA) standards in performing this business function. 4. Responses to routine provider requests are automated and self-service is provided via a web portal. 5. Accuracy of responses improves as information used in the process becomes standardized, automated, and easily accessible. 6. Cost-effectiveness improves through the use of automation and self-service portals, thus

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		business day or more. 7. Very little collaboration with other agencies occurs. 8. Staff is burdened by performing manual research and manual responses, which impacts accessibility of information, efficiency, accuracy, and timeliness. 9. Stakeholder satisfaction is not actively measured.		improving the efficiency of the business process. Staff can focus on exception resolution. 7. Stakeholders have no delay in obtaining clear and thus useful responses.
PM03 Perform Provider Outreach	**1**	1. The business process is informal and inconsistent; the PMA focuses on meeting compliance thresholds. 2. Standard educational and policy information for enrolled providers is maintained electronically by the agency and is distributed to the providers via improved communication mechanisms such as electronic media or web portal. 3. Identification of targeted providers is based on provider registry data and claims history. Outreach to non-enrolled population, when/if conducted, is random. 4. The agency collaborates with other entities to adopt standards. 5. Functionally, linguistically and culturally competent materials are not routinely produced. 6. Because the outreach requires a mix of manual and automated processes, they are costly to perform. 7. Material is manually developed and disseminated. Accuracy level is rated as adequate. 8. Higher cost to lower number of outreach	**2**	1. Increased use of agency standards for provider data improves identification of targeted, enrolled providers; and aids in identification of provider network gaps in specialty, location, cultural, and linguistic needs. 2. Standard educational and policy information for enrolled providers is maintained electronically by the agency and is distributed to the providers via improved communication mechanisms such as electronic media or web portal. 3. The process becomes more formalized and the PMA adopts automated workflow to ensure accuracy and proper reviews 4. Better demographic data improves ability to target. Provider registries use standardized contact data, including NPI address standards, to alleviate postal delivery failures. 5. Some inter-agency collaboration exists with other entities to adopt HIPAA standards and EDI transactions. 6. Timeliness, accuracy, and efficiency improve as automation and HIPAA standards become integrated into the business process. 7. The PMA easily obtains information and exchanges data with other entities in the intrastate through the adoption of industry standards and improved demographic collection.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		processes. 9. Provider information is maintained and available, primarily on a scheduled or request basis to other business processes and users. 10. Level of stakeholder satisfaction may be measured by provider's surveys, but is not likely monitored on a regular basis.		8. The use of the provider portal makes outreach information available on demand, thus improving the cost effectiveness and efficiency of the business process. 9. Increased interaction with providers yields more consistent information about their level of satisfaction. Business Process improvements net increased levels of satisfaction.
PM07 Manage Provider Grievance and Appeal	**1**	1. This is a paper-based process which relies upon disparate programs to file, manage, and resolve grievances. 2. Grievances and appeals are filed via fax and USPS. Confidential documents are transferred by certified mail. Process is not formalized. 3. There are clearly defined policies and procedures for providers to follow. The PMA has a review board to review cases, but there is no formal management plan for the business process. 4. There may be inconsistencies between similar cases. 5. Most information is provided in hard copy and most business processes are manual. This impacts efficiency, timeliness, and accuracy. 6. Due to manual processes, there is a high relative cost to perform the business process. 7. Information is researched manually resulting in inconsistencies among case files; there are no standards for case data. It is difficult to measure accuracy. 8. Requests are managed	**2**	1. Documents are scanned and the case file is automated and can be shared among case workers. 2. The PMA begins to centralize and standardize the administration of the business process, which increases coordination of cases and allows for consistent application of rules and appeals. 3. Local documentation standardization is established and a formal management plan exists. The Commonwealth collaborates with other entities and begins to adopt nationally recognized standards. 4. There is more consistency in the steps taken in the review and resolution process. 5. Automation in development of case file, scheduling hearings, and storing documents results in reduction in end-to-end time to 100 business days or less. 6. The accuracy of the information used in the process improves through the use of nationally recognized standards. 7. Automation and standardization of the business process improves the cost effectiveness and efficiency. 8. Accuracy is improved through automation. Monitoring of performance measures provide input for process improvements. 9. Stakeholders benefit from introduction of automation and standardization to speed up the case resolution.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		manually resulting in delays. Accessibility is rated as poor. 9. Process is labor-intensive. 10. Low level of stakeholder satisfaction due to demands of and delays in the process.		
PM08 Terminate Provider	**1**	1. This process is primarily performed manually and is paper-based. 2. The Commonwealth focuses on meeting compliance thresholds and there is very little collaboration with other agencies to standardize tasks or information exchange. 3. Timeliness to complete the process, cost effectiveness, accuracy, efficiency, and data accessibility are impacted by the lack of standardization and the manual processes. 4. Stakeholder satisfaction with the business process is rated as low.	**2**	1. The PMA automates the process as much as possible within the intrastate and stores the enhanced provided termination information within the Commonwealth. 2. Industry and other nationally recognized standards are used for the intranet exchange of information. 3. Collaboration with other state and federal agencies and entities occurs in adopting HIPAA and EDI transactions, thus improving timeliness and accuracy of information used in the process. 4. Information is easily obtained and exchanged with intrastate agencies due to the adoption of national standards. 5. Automation improves the cost effectiveness, and efficiency of the business process and allows the PMA to focus on exception resolution. 6. Stakeholder satisfaction improves as automation and standardization increases, thus providing clear and useful information.

3.9 Performance Management

3.9.1 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.

3.9.2 Performance Management As Is Summary

Numerous programs and business units within the Medicaid Enterprise perform or have a role in managing providers in Pennsylvania. These include but are not limited to:

- DPW
  - OA
    - BFO
    - BPI
  - OCYF
  - OCDEL
  - ODP
  - OIM
    - Data Investigations and Analysis Section (DIAS)
  - OLTL
  - OMAP
    - BDCM
    - BFFSP
      - Division of Pharmacy
    - BMCO
  - OMHSAS
- Fraud and Abuse Hotline
- OAG
- OIG
- U.S. Department of the Treasury
  - Office of Comptroller

Review of the Medicaid Enterprise indicates that four Performance Management business processes currently are at MML 1 and one process is a MML of 2.

The primary factors affecting maturity ratings across the Performance Management business area include the following:

- Data exchanges are conducted with increased automation and enhanced parameters are used for case identification
- Increased availability of data improves data usefulness for performance monitoring, management reporting, and analysis
- Pennsylvania uses web portals, email distribution, and tracking for respondent communications
- Combination of manual and automated processes results in increased efficiency
- Internal standardization of data, use of HIPAA data exchange standards, and increased automation improves access and accuracy
- Increased automation, coordination with other processes, and introduction of standards improves efficiency and communication formats are standardized
- Stakeholder satisfaction is measured across all business processes

Pennsylvania manages about 3,500 cases per year with the completion process of about 6-12 months. Suspected criminal activities in Pennsylvania are investigated by the Pennsylvania Attorney General, Medicaid Fraud Control Unit (MFCU). Pennsylvania utilizes a FADS, which contains all FFS and MCO claim data. The Health Plan Management process relies heavily upon access to data for analysis and reporting. The enterprise data is transmitted between systems using automated processes which improve the timeliness, consistency, and access to data. This process ensures that the data in the Pennsylvania

reporting database (EDW) matches the data from the claims processing system (PROMISe™) and other systems.

The PROMISe™ system is the MMIS for Pennsylvania, which contains all provider information and adjudicates the claims. All provider applications and provider agreements are obtained through the Electronic Provider Enrollment Automation Project (ePEAP). Claims information is obtained through the FADS system while licensing information is obtained through the DOS and the DOH websites. MEDICHECK, Healthcare Integrity Practitioner Data Bank (HIPDB), and the List of Excluded Individuals/Entities (LEIE) store all information concerning disciplinary actions taken by other agencies, states, and the federal government.

The Department generates and mails member Explanation of Benefits (EOBs) to a sample population. The system also supports the ability to generate targeted EOBs.

3.9.3 Performance Management To Be Summary

As established during the Commonwealth's EVS, this business area is considered a low priority for capability improvements. As a result, the resources dedicated to improvements to this area will be made available once higher priority areas such as Member Management and Care Management have been addressed. The Commonwealth will focus on making improvements to sharing data, consolidating redundant systems, promoting self-service for its business partners, and managing stakeholder satisfaction.

The Commonwealth's goals for Performance Management as determined by Executive Leadership are as follows:

- Enhance access to external information for data validation, e.g., national fraud database
- Enhance Quality Assurance (QA) and utilization management to detect fraud and abuse
- Provide integrated access to provider activity, such as linking questionable billing and malpractice
- Implement capability to use EHRs in conjunction with claims and encounter data to support various program activities, audits, and accommodations
- Standardize all data and processes using electronic formats
- Eliminate barriers to improvements, e.g., requiring providers to submit paper forms due to a Commonwealth regulation requiring "handwritten" signatures
- Communicate and educate all provider types regarding best practices in billing and referrals
- Develop a comprehensive universal profile, offering a single view of a patient for use in online tracking of client activity
- Increase oversight of operations
- Promote use of online notifications and alerts to providers

Additional functional capability improvements for Performance Management include the following:

Performance Management Tool:

- Implement a web based performance management tool where cases can be managed by the appropriate unit and all information needed for case management is available
- This tool needs to support use by other departments, state agencies, MCOs, and other partners
- The tool needs to start with a library of interfaces using initial batch exchanges and then moving to near real-time exchanges
- The initial data set must include an integration of all existing performance management tracking data repositories
- Tool must support enhanced note taking, data capture, and automation
- Tool must support batch data loads

Interfaces:

- Promote real-time interfaces (vital statistics, U.S. Citizenship and Immigration Services (USCIS), SSA, IRS, DLI) at eligibility determination and ongoing interaction to ensure appropriate decision making
- Establish an interfacing library of all sources of data that would include providers, members, contractors, and many others

Integrated and Federated Data:

- Promote a centralized or federated data model to support case identification
- Integrate with federal and other data sharing partners using as common a data model as feasible. This is an iterative process and will start with common and national data exchanges as a pilot and then move out from there.
- Explore the integration of case management data with EHR data. Considerations include privacy, breaches, the role based structure, and the nature of plan-of-care information.
- Fully vet integration and data sharing capabilities to ensure policy and system functionality actually meets the business needs as stated

Other:

- Integrate metrics reporting for the Prepare EOB process
- Expand the EOB process to other programs if applicable
- Enhance QA and utilization management functionality will include enhanced claim editing, where at point of adjudication the claim is scored for risk
- Perform a cost benefit in order to determine if decisions would be a good addition to the system
- Implement comprehensive universal profile functionality to use predictive modeling, dynamic mean analysis, and peer group comparisons
- Increase oversight of operations to include capturing and analyzing metrics to support policy decisions. Analysis must be user configurable to meet changing business needs.
- Enhance money-follows-the-entity initiatives to track public expenditures across all offices and departments for any given member, provider, contractor, or county. This functionality will be used to identify any duplicate payments, identify funding sources, and other fiscal analysis. This will be piloted expanding the pocket of functionality that exists today, then expand to statewide, and then expand to interstate.
- Provide functionality during intake of either member or provider to identify data patterns and identify high risk records. These records will then be flagged for additional oversight.

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 12: Performance Management Maturity Level

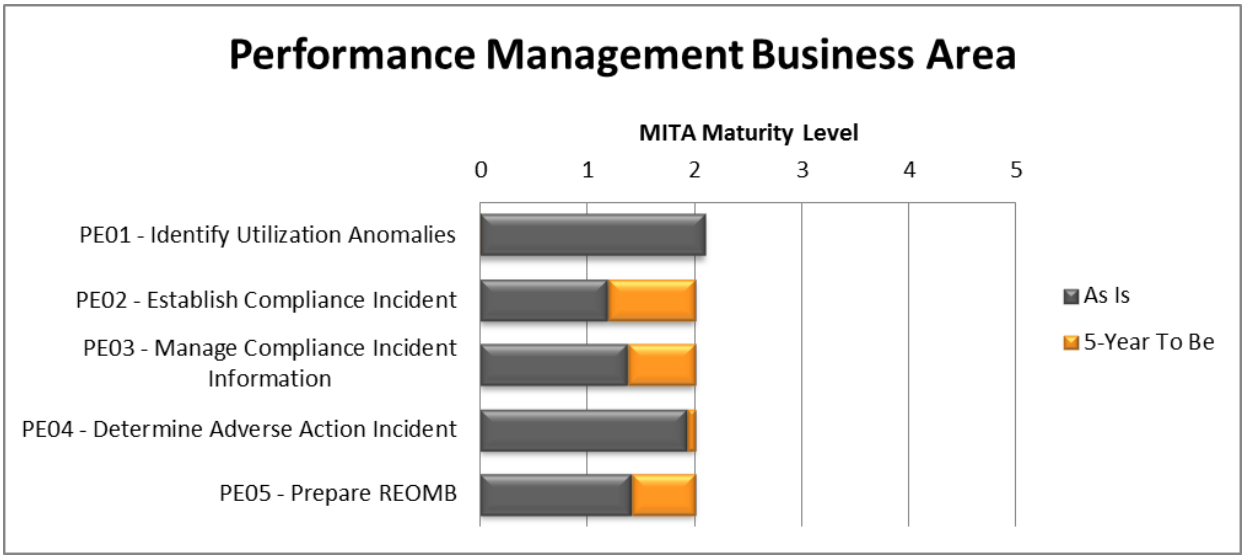


Table 10: Performance Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
PE01 Identify Utilization Anomalies	**2**	1. Process is a mix of manual and automated steps. All requests are automatically tracked. 2. Proactive reviews are performed. 3. The process is supported by effective automation which increases the accuracy of results. 4. Manual intervention is supported by testing tools and peer reviews to minimize the potential for human error. 5. The use of automated data mining tools for this process keeps the number of staff at a minimum level and effectively identifies candidate cases. 6. The data used by BPI is accessed electronically using an automated process resulting in a high degree of accuracy.	**2**	1. Process is mostly automated with few manual process steps. 2. Proactive reviews are performed. 3. Data and processes are using standardized electronic formats. 4. Claim editing has been enhanced where at point of adjudication the claim is scored for risk and high score causes the claim to pend. 5. Improved use of internal data standard and HIPAA data standards continues to increase access and accuracy. 6. Overall process time takes between 15 minutes up to 1 week to perform all analysis and additional spinoff projects that may arise during review. 7. The automated data mining tools continue to keep staff required for this process at a minimum level and it effectively identifies candidate cases. 8. Access to external information for data validation has been enhanced.
PE02	**1**	1. There are duplicate	**2**	1. A single integrated system to house

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
Establish Compliance Incident		processes in multiple parts of the organization. 2. The opening of a case is a manual process. 3. Cases are being tracked in the BPI Case Tracking System.		and track all activities has made the process more efficient. 2. Portions of the process have been automated. 3. The timeliness of the process has improved.
PE03 Manage Compliance Incident Information	**1**	1. Current process meets the Commonwealth's needs but can be more automated. 2. Process is manual but accuracy is high. 3. The costs increase significantly for pay and chase cases. 4. While the process is manual the data is relied upon as accurate.	**2**	1. Automation has integrated the case management systems with CIS and claims processing system. 2. The use of HIPAA standard transactions has improved the accuracy of information 3. Automation has improved the timeliness of the process. 4. The Commonwealth has adopted the MITA framework and other national standards.
PE04 Investigate Adverse Action Incident	**1**	1. Data is primarily electronic and easily accessible. 2. The process is considered to be timely 3. Data is primarily electronic and easily accessible. The process is performed in a cost-effective manner. 4. The process is documented, maintained, and repeatable. 5. The process effectively detects and prevents FWA.	**2**	1. The process is integrated within the Medicaid Enterprise. There is improved coordination between the Medicaid agency and other stakeholders in relation to this process. 2. Process is mostly automated with few manual process steps. 3. Increased use of electronic interchange and internal data standards increase coordination and consistency. 4. Data validation is mostly automated with few manual activities. 5. The PME begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction.
PE05 Prepare REOMB EOB	**1**	1. EOBs are generated using automated sampling and correspondence, but it is primarily manual after letter generation. 2. Tracking EOB responses is manual. 3. There are electronic copies of all outgoing correspondence. 4. The lack of automation is keeping stakeholder satisfaction low.	**2**	1. The process is a mix of manual and automated. The automated sampling continues with additional process steps becoming automated. 2. HIPAA and internal data standards are implemented. 3. Explanation of Medicare Benefits (EOMB) responses are tracked automatically and electronically. 4. Alternate EOB formats, linguistic, and cultural adaptations are available. 5. Stakeholder satisfaction is tracked and measured.

3.10 Care Management

3.10.1 Overview

The Care Management business area contains business processes that focus on individual care management (Establish Case and Manage Case), maintenance of registries related to specific health issues (Manage Registry), and population management (Manage Medicaid Population Health).

The Pennsylvania Care Management business area illustrates the growing importance of care management within the Medicaid program. Care Management contains business processes that have a common purpose (e.g., identify clients 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. In Pennsylvania, population management targets groups of individuals with similar characteristics and needs and promotes health education and awareness.

3.10.2 Care Management As Is Summary

Numerous programs and business units within the Medicaid Enterprise perform or have a role in managing care. These include but are not limited to:

- DOH
  - Office of Community Services and Advocacy (OCSA)
  - HCBS
- DMVA
  - Army Education Center
  - Behavioral Health
- DPW
  - OA
  - OCYF
  - OCDEL
  - ODP
    - BAS
  - OLTL
  - OMAP
    - BFFSP
    - BMCO
- PDA
  - Bureau for Advocacy, Protection, and Education
  - Bureau of Pharmaceutical Assistance

Over 80 percent of people are covered by mandatory managed care in Pennsylvania. Pennsylvania utilizes Legislative input, Governor's office input, advocacy groups, and federal and state initiatives as the primary drivers for Medicaid health management. For claims adjudication, HCSIS, and PROMISe™ are generally used while SAMS and HCSIS are used to support claims validation for various programs in Pennsylvania. CaseNet/CareManager is utilized to support Intense Medical Case Management. PA referral processes have been eliminated with the termination of the ACCESS program and is now managed completely by Pennsylvania MCOs. Ingenix/ImpactPro is no longer used for predictive modeling.

The As Is review of the Medicaid Enterprise indicates all Care Management business processes currently are determined a MML 1, indicating predominately manual processes with a mixture of improved communication mechanisms. Data exchanges are conducted manually, electronically maintained, and data

is distributed by electronic media or web portal. Data is in various locations and is inconsistent across programs. Data accuracy and documentation updates depend on manual efforts and provider accuracy.

3.10.3 Care Management To Be Summary

As established during the Commonwealth's EVS, this business area is considered a **high** priority. The Commonwealth will focus on increasing its case management business area, which will promote self-service, increase data accuracy, and increase efficiency and effectiveness of communication with members to manage their care, and implement the use of various monitoring technologies to enhance member care efficiently and effectively.

The primary functional capability improvements across the Care Management business area include the following:

- Capture of all available information about a member's clinical encounters and other care information by 2015
- Ensure that every client has a medical home and that their care is managed
- Ensure active consumer participation in health care decisions
- Balance HCBS
- Provide and ensure that everyone receives the best care and ensure continuum of care
- Improve the quality of services to consumers and providers in all our health care delivery systems
- Improve technology to move towards SOA where feasible and monitor and improve care outcomes
- Provide a secure web-based care management system
- Develop a strong decision support tool to automatically manage Federal and State care program needs across all systems
- Development of a Community Shared Services (CSS) (Pennsylvania eHealth Partnership Authority — HIE)
- Development of a Commonwealth Internal Health Information Exchange (CI-HIE)
- Provide accessible clinical quality data (e.g., lab data) to all business partners
- Develop a web enabled environment for providers to enter prior authorizations (PAs)
- Reinstitute Ingenix or other predictive modeling software to assist with risk assessment
- Achieve total electronic processing
- Develop policy changes that enable full automation
- Enhance Drug Rebate Program processes. FFS is all inclusive but the MCOs are lagging behind.
- Develop client participation process where the client financially participates in their healthcare costs
- Planning, assessment, and compliance with ICD-10 and Version 5010, version D.0 and version 3.0
- Interface with future electronic health/medical records systems
- Interface medical and pharmacy information with case management processes in order to communicate across programs concerning total client care
- Implement centralized, business rules driven system accessible by all parts of the Enterprise
- Workflow management system would include automatic ticklers and alerts
- System would respond to the provider with an automatic, electronic response (example: pend, deny, approved)
- Ensure that the capability is available to all units that need to have oversight with this type of activity. (Care management, waivers, etc.)
- Ensure that the process for provider referrals includes capabilities needed for MCOs
- Development of a CSS (Pennsylvania eHealth Partnership Authority — HIE)
- Provide accessible clinical quality data (e.g., lab data) to all business partners

Additional functional capability improvements across the Care Management business area include the following:

- Implement centralized repository of all care management data. This process would allow one-stop access to a secure, web-based care management system where data and interfaces are standardized, private and secure via compliance with state and federal regulations. Clinical data is collected electronically from all internal and external sources (e.g., critical care notes, plan of care notes, patient history, medication history, discharge notes, general memo, other non-medical data, individual support plan (ISP), and field notes).
- Establish an Enterprise-wide collaboration. Establish and maintain a collaborative, enterprise-wide web portal that can be accessed by external entities for data validation and verification. Implement a collaborative dashboard for all care management activities. Modify state policy, laws, and regulations to ensure effective case management Stakeholders will need to determine how this will look, how data will be included.
- Establish a hierarchy of funding sources and priorities to maximize dollars used within the system according to new policies established by the Enterprise. There are funding sources available for States to improve their member benefits, such as:
  - In May 2011, HHS provided guidance for availability of over $100 million in funding for up to 75 Community Transformation Grants. Created by the ACA, these grants are aimed at helping communities implement projects proven to reduce chronic disease, violence and injury, and improve mental health and equity.[10]
- Establish a care management governance structure for business, technology, and information to manage the ongoing use and updates to the care management business area. This includes an agency of record and system of record for contradictory data and integration of data in a process where a common data model can be easily adapted. Data models require governance to establish priority of standards adoption and the data modeling needed to occur early in the MITA To Be roadmap to establish the baseline for systems development.
- Implement a workflow management system. Integrate county-wide processes into the care management workflow to ensure effective and efficient care management where scheduling, benefit monitoring, ticklers, and alerts are processed electronically.
- Integration of predictive modeling tools for care management will provide effective goal setting and progression management to analyze the effectiveness of the program. Ability for user defined queries on demand and save existing queries on a regular basis (e.g., integration with vital statistics, data warehouse, registries).

[10] The official funding opportunity announcement for the Community Transformation Grants can be found at www.Grants.gov by searching for CDFA 93.544. For more information about the grants, visit www.cdc.gov/communitytransformation.

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 13: Care Management Maturity Level

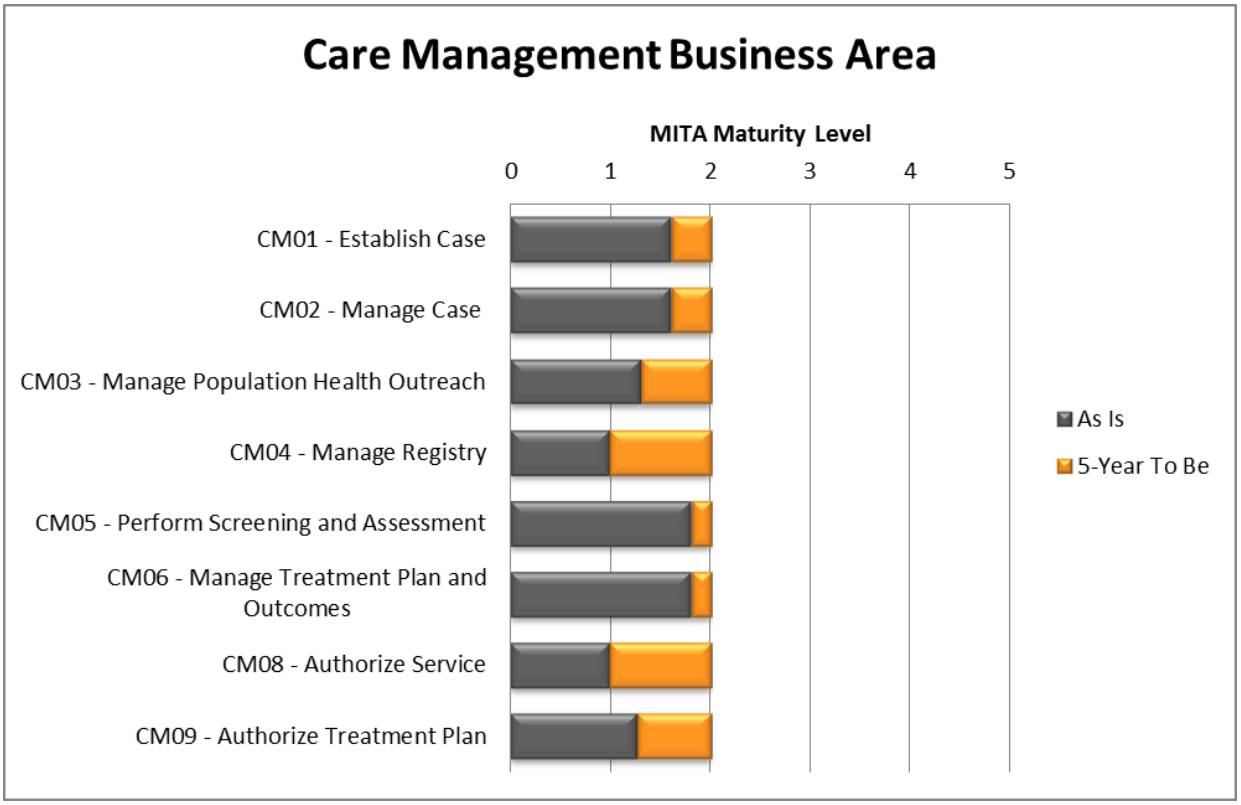


Table 11: Care Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
CM01 Establish Case	**1**	1. The PMA uses a mix of manual and automated processes. 2. Data may be received electronically, by phone or by mail, and then it is manually evaluated. 3. The Commonwealth uses HIPAA and state specific standards. 4. The PMA collaborates with other agencies to adopt HIPAA standards and EDI transactions. Authorized users are permitted to access other databases and retrieve pertinent information about the member (i.e.,	**2**	1. The process is fully automated to the extent possible. The PMA adopts industry and other national standards for state HIE. 2. The PMA collaborates with other intrastate agencies, entities, and RHIOs to adopt national standards and to develop and share reusable business services. 3. HIPAA standard transactions further improve the accuracy and the accessibility of information used in the process. 4. The cost-effectiveness and efficiency of the program

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		eligibility, claims history). 5. Manual processes may adversely impact timeliness, but the process meets mandated requirements as specified by law. 6. Manual processes can adversely impact accuracy. Use of direct data entry for information collection is manually intensive and susceptible to error. 7. Information is stored in disparate systems and access to data can be difficult for some programs. 8. Combination of manual and automated processes results in increased efficiency. 9. Due to the low number of automated and standardized tasks, there is a relatively high cost to perform the business process. 10. The effort to identify candidates can vary. Some parts of the process are manual and time consuming. More automation would increase the efficiency of the process. 11. The results of the process are very accurate because decisions are based on defined eligibility criteria. 12. Automation of some parts of the business process and defined criteria provides clear and useful information which positively impacts stakeholder satisfaction.		increase through the application of automation. Staff is able to focus on exception resolution.
CM02 Manage Case	**1**	1. The process uses a mix of manual and automated processes to accomplish tasks. 2. HIPAA and state-specific standards are used to monitor compliance thresholds established by state and federal regulations, professional standards, or administrative rules governing the appropriate management of a case. Case data is	**2**	1. Increases in automation improve the process. 2. Staff can focus on exception resolution and improve the cost effectiveness of the business process. 3. Efficiencies and accuracy are gained through increased automation and Commonwealth standardization of the business process. 4. Decision-making for the process is based on PME policy which has been automated resulting in

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		indeterminate. 3. The Commonwealth collaborates with other entities to adopt HIPAA standards and EDI transactions. 4. An automated process documents care plan and tracks cases. Authorized users are permitted to access other databases and retrieve pertinent information about the patient (i.e., eligibility, claims history). 5. The process uses automated reports for tracking compliance with state and federal guidelines for case management and for the delivery of care, improving timeliness. 6. Automation and use of HIPAA standards increases accuracy of, and accessibility to, the information used in the business process. 7. The process meets Commonwealth budget guidelines or established dollar thresholds for case savings, but the cost to perform the process is relatively high. 8. Manual processes result in greater opportunity for human error. 9. The process meets Commonwealth and federal expectations for member education, coordination of care between providers, and maintaining the plan of care. Decision-making for the process is manually performed using established parameters and guidelines and may result in some subjective and inconsistent decisions. 10. Stakeholder satisfaction is negatively impacted with few resources dedicated to improvement and few measurements in place,		uniform decisions in most situations. Outliers are reviewed on a case-by-case basis using state and federal guidelines. Process results are more consistent. 5. The Commonwealth begins to identify gaps in level of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		e.g., reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.		
CM03 Manage Medicaid Population Health	**1**	1. A mix of manual and automated steps is used to accomplish the process steps. Mostly manual compilation of data is required. 2. Very little collaboration with other agencies occurs. 3. Use of automation improves the timeliness of the business process; however, the process consists primarily of manual processes (e.g., review of reports, telephone contacts, facsimile, letters) to gather and share information about the status of health in the population and to identify targets for outreach. These manual activities negatively impact timeliness. 4. Manual processes can adversely impact accuracy. Direct data entry for information collection is manually intensive and subject to errors. 5. Information needed for the business process may be stored in disparate systems; however, accessibility is improved through the introduction of HIPAA standards. 6. The process operates within Commonwealth budget constraints. The benefits vary depending upon the types of studies undertaken, the population studied, and the outcome of the research and/or findings. 7. Manual activities may negatively impact accuracy. 8. Stakeholder satisfaction is low with few resources dedicated to improvement and few measurements in place.	**2**	1. At this level, the Commonwealth will use a mix of HIPAA and state-specific standards in the business process. 2. The Commonwealth collaborates with other agencies and entities to adopt HIPAA standards and EDI transactions. 3. A variety of information systems is used by the PMA for research and reporting, as well as to identify members who are receiving medical care from multiple agencies. 4. Increased automation improves the timeliness and efficiency of the business process. 5. Internal standardization of data, the use of HIPAA data exchange standards, and increased automation improves the accuracy of the information used in the business process. 6. The process is more cost effective that at Level 1 due to the introduction of data standards and automation. The use of automation reduces and allows additional benefits to be gained by focusing on increased reporting, more effective outreach, more directed outcomes, and automated analysis. 7. The PME begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction.
CM04	**1**	1. This process uses a mix of	**2**	1. This process uses a mix of manual

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
Manage Registry		manual and automated processes for data collection. Compiled data includes both information gathered manually and data entered into the registry and data files uploaded to the registry in standard data formats. 2. The process uses minimal standards for collection of data into the registry and local data standards. 3. This process meets State and Federal guidelines for data collection timeliness for reporting to the Registry. The Medicaid Enterprise does not interface with the Registries currently maintained by DOH. 4. Data may be incomplete, inaccurate, irrelevant, and untimely. Often additional information must be requested. 5. Access to data is controlled manually. Data access may take several business days. 6. The process relies primarily on manual activities. 7. The process meets Commonwealth budget guidelines. 8. Decisions are manual and based on non-standard information, which may result in inconsistent decisions. 9. There are issues regarding timeliness, accuracy, completeness of the Registry data thus negatively impacting stakeholder satisfaction.		and automated processes for data collection. Compiled data includes both information gathered manually and data entered into the registry and data files uploaded to the registry in standard data formats. 2. The process uses State and Federal standards for collection of data into the registry. 3. The process can be completed, in less time. 4. Accuracy and consistency of data improves due to increased use of automation and data standards. 5. The process uses online access to Registry data but compilation of the data is a mixture of manual and automated activities. Data access takes less time. 6. Efficiency increases with automation allowing staff to focus more on analyzing Registry data and issuing alerts when problems are detected. 7. Cost effectiveness increases with automation and elimination of local standards. 8. Decision making for the process is automated based on Medicaid enterprise policy resulting in more uniform decisions. 9. Satisfaction improves due to automation.
CM05 Perform Screening and Assessment	**1**	1. Pennsylvania uses a mix of manual and automated processes to accomplish tasks. 2. The Commonwealth applies a mix of HIPAA information standards and state-specific standards in the business process. Accuracy, timeliness, and accessibility	**2**	1. Through increased automation, timeliness improves. Timeliness exceeds legal requirements. 2. Automation improves the process and allows the Commonwealth to focus on exception resolution. 3. Cost-effectiveness and efficiencies are improved through collaboration and automation.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		of data used in the process are improved through the application of HIPAA standards. 3. The Commonwealth collaborates with other agencies and entities to adopt HIPAA standards and EDI transactions. 4. The process meets mandated requirements for timeliness. 5. There is a high relative cost to perform this business process due to low number of automated, standardized tasks; some efficiency is gained through the adoption of HIPAA standard transaction. 6. Stakeholders are generally satisfied.		
CM06 Manage Treatment Plan and Outcomes	**1**	1. Manual and automated processes are used to accomplish tasks. 2. Through the application of HIPAA information standards and state-specific standards, requirements for timeliness are met. 3. Very little collaboration occurs with other agencies to standardize information exchange or business tasks. 4. HIPAA standard transactions improve accuracy of information. 5. While information may be stored in disparate systems, the use of automation and HIPAA standards increase accessibility, and improve efficiency. 6. Automation improves the business process and allows staff to focus on exception resolution. 7. Automation and standardization provides clear and useful information. 8. Stakeholder satisfaction is greater than Level 1.	**2**	1. At this level, the Commonwealth collaborates with other agencies and entities to adopt HIPAA standards and EDI transactions. 2. Process timeliness improves through use of automation. Timeliness exceeds legal requirements.
CM08 Authorize Services	**1**	1. The business process is primarily manual. Requests are most often received and	**2**	1. The business process is a mix of manual and automated processes.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		responded to via phone, mail, and fax. 2. Standard transactions are not utilized for this process; the PMA has developed unique paper forms to support the process. 3. Commonwealth business rules are manually validated and require many business days for approval and implementation. 4. The accuracy of the source information is dependent upon the content and completeness of what is submitted by the provider. 5. Access to other internal information is readily accessible, usually electronically; however, there is no common source. 6. The cost-effectiveness of the business process is impacted by the degree of manual processing, non-standard formats, and incomplete provider submissions. 7. Stakeholder satisfaction does not appear to be measured and opportunities for improvements are not proactively identified.		Requests are received and responded to via paper, phone, fax, and electronic media. 2. At this level, the Commonwealth uses state-specific forms but has also implemented HIPAA X12 transactions. 3. Some automation of standardized business rules has occurred. 4. Timeliness, accuracy of data, and cost effectiveness will be improved through standardization, automation, and adoption of HIPAA transactions. 5. Automation and standardization provides clear and useful information and stakeholder satisfaction with the business process improves.
CM09 Authorize Treatment Plan	**1**	1. Electronic transactions are used, but the process is primarily manual. 2. Business rules changes require many days for approval and implementation 3. There is very little collaboration with other agencies occurring. 4. The highly manual process and non-standard information impacts the accuracy and accessibility of information. 5. The quality of the outcome is impacted by the manually intensive process. 6. Stakeholder satisfaction with the process is low.	**2**	1. Process continues to be a mix of automated and manual process steps with requests submitted via X12 277/278 transactions and web portal. 2. Automation of standardized business rules is introduced. 3. At this level, the PMA collaborates with other entities to adopt HIPAA standards and EDI transactions. 4. Timeliness of the business process improves through automation. 5. Increased automation for the decision making process helps to ensure the accuracy of the results. 6. The efficiency of the business process and cost benefits to the Commonwealth are improved through the increased use of automation and the increased use of HIPAA 277/278 transactions.

3.11 Health Plan Management

3.11.1 Overview

The Health Plan Management business area includes the strategic planning, policymaking, benefit plan management, 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 include 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.

The Health Plan Management business area houses the strategic planning, policymaking, monitoring, and oversight activities of the Commonwealth. These activities depend heavily on access to timely and accurate data and the use of analytical tools. This business area uses a specific set of data (e.g., information about the benefit plans covered, services rendered, expenditures, performance outcomes, and goals and objectives) and contains business processes that have a common purpose (e.g., managing the Medicaid program to achieve the Agency's goals and objectives such as by meeting budget objectives, improving customer satisfaction, and improving quality and health outcomes).

This business area includes a wide range of planning, analysis, and decision-making activities, including benefit plan design, rate setting, health care outcome targets, and cost-management decisions. This is the heart of the Medicaid Enterprise and the control center for all operations.

As the Medicaid Enterprise matures; Health Plan Management benefits from immediate access to information, addition of clinical records, use of 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.

3.11.2 Health Plan Management As Is Summary

The OMAP Health Plan Management environment is a mixture of manual and automated processes supplying information to the management teams across the PME about the status of the program, the effects of projects across all system platforms, and priority setting for future improvement. The workflow is outlined below:

Program Administration — The OMAP Executive team reviews and updates the PMA goals and objectives annually at an executive retreat. In preparation for the review, the bureau directors are asked to review the annual process with staff and bring suggested ideas and updates to the retreat. After the retreat, updated goals and objectives are shared with the entire staff of OMAP and modifications to the program policies and the State plan begin. These modifications are extremely manual and can take anywhere from 1 to 18 months to complete, relying on paper documents, manual intervention, and laborious review and authorization cycles.

Benefit Administration — Once all policies and plans are approved, modifications to the MA benefit package(s) can be made. These modifications could take anywhere from two to nine months. State plan, rates, benefits, formulary updates, and external review (e.g., CMS) requirements add time to the processes. Once updates are approved for implementation, notifications are made to affected parties and changes are scheduled with the appropriate vendors and managed care plans. Notifications are prepared, reviewed, scheduled, and sent by various media (e.g., USPS, Intranet). Part of the Pennsylvania methodology is the regular meetings in place to review enhancements to evaluate the timeliness of the processes.

Program Quality Management — The Pennsylvania quality program environment has many steps that include a mixture of manual and automated processes. Data is electronically obtained and a majority of the reporting is electronic. Manual intervention occurs when evaluating and validating data to be used in the ongoing and ad hoc reports. The sign-off process slows down the processes. Measurement of the program is limited to producing documentation and reports for oversight stakeholders (e.g., Governor's Office, CMS) without measuring those processes that fulfill the business area's goals and objectives.

Program Information — The majority of program data is housed in the PROMISe™ system. OMAP works closely with the vendor to receive and modify the program management information housed in the EDW. Protocols are defined in the use of the data to meet the needs of Pennsylvania as well as developing programs and extracts in response to requests for data. This data is shared via extracts and interfaces to various vendors and internal and external entities. Internal systems can handle external data sources which are loaded directly into PROMISe™. Once the data is available and validated, reports are produced electronically or manually to support the Medicaid Enterprise.

Numerous programs and business units within the Medicaid Enterprise perform or have a role in the Health Plan Management business area. These include, but are not limited to:

- CMS
- DOH
- DMVA
- DPW
  - OA
    - BIS
    - BPI
      - TPL
  - OB
  - OCDEL
  - OCYF
  - Office of Comptroller
  - ODP
  - OGC
  - OIM
  - OLTL
  - OMAP
    - BDCM
    - BFFSP
      - Division of Rate Setting
    - BMCO
    - BPAP
    - Medical Assistance Advisory Committee (MAAC)
    - OCQI
  - OMHSAS
  - OPD
- Governor's Office of Administration
  - Policy Office
  - Budget Office
    - Office of Healthcare Reform
    - PDA
    - PDE

- Pennsylvania Healthcare Cost Containment Council
- PID
- U.S. Department of the Treasury

Review of the Medicaid Enterprise indicates that seven Health Plan Management business processes currently are determined a MML 1 and one process is has a MML of 2.

The primary factors affecting maturity ratings across the Health Plan Management business area include the following:

- Business processes are a mix of manual and automated steps
- Data exchanges are a mixture of manual and automated processes between stakeholders
- Research and analysis are labor intensive
- The process is documented, considered to be efficient, and does not lend itself to automation
- Data exists on several data stores throughout the Medicaid Enterprise. An individual process will determine the positive or negative effect of whether or not retrieving data from many sources is effective, efficient, and/or cost-effective.
- There is an exceptional amount of data available in this business area but the methods to access and retrieve data are difficult. The use of spreadsheets is the primary method for collecting data and reporting results.
- Ongoing, manual data manipulation during various steps of the processes affects the cost-effectiveness of this process
- The data in disparate locations, delays in data availability, lack of an efficient workflow, and the labor intensive manual review process has a negative effect on Stakeholder satisfaction

3.11.3 Health Plan Management To Be Summary

As established during the Commonwealth's EVS, this business area is considered a high priority for capability improvements. As a result, the resources dedicated to improvements to this area are to be managed between other high priority areas such as Member Management and Care Management. The Commonwealth will focus on making improvements to sharing data, consolidating redundant systems, promoting self-service for its business partners, and managing stakeholder satisfaction.

While some processes will remain manual due to the nature of the process, there are others that can be enhanced by the introduction of automated processing tools such as COTS applications, workflow products to accelerate authorization processes, and upgraded measurements for enhancing quality.

The Pennsylvania goals for Health Plan Management, as determined by the Executive Leadership are:

- Develop automated, state-of-the-art performance measures and reporting
- Enhance automated management of FMAP and FFP
- Expedite, enhance, and automate the Policy Development process and integrated workflow
- Improve financial reporting capacity including data pulls, details, and definitions
- Simplify and automate creation and management of health care benefit plans
- Automate the Rate Setting process
- Increase the ability for Policy Development to interact with other departments
- Integrate Policy Development with operational improvements to ensure that new policy is achievable
- Review and revise the policy and/or regulation for hand written signature to accept electronic authentication

Additional functional capability improvements for Health Plan Management include the following:

- Review policy to streamline rate setting and pricing to try to minimize mass adjustments
- Review pricing methodologies
- Comprehensive review of how rates and reimbursements even occur. Explore reimbursement based on health outcomes rather than the current transactional model.

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 14: Plan Management Maturity Level

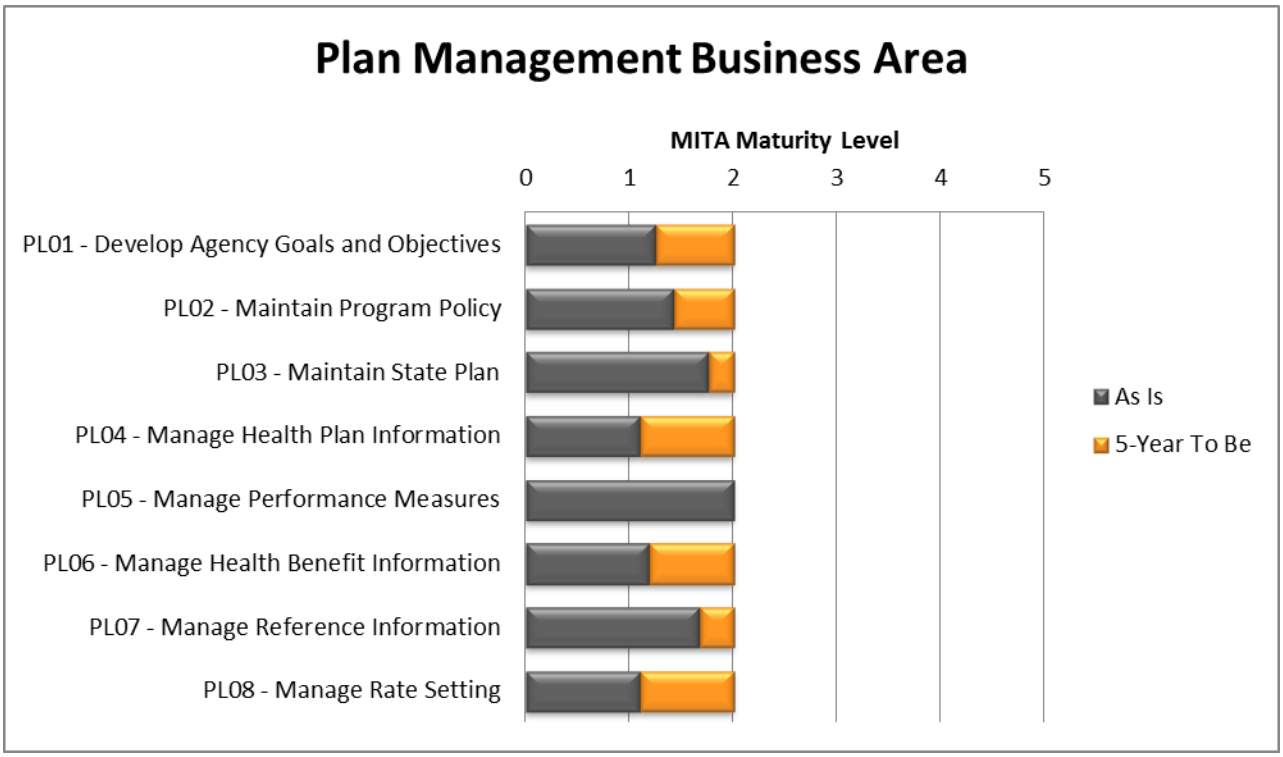


Table 12: Plan Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
PL01 Develop Agency Goals and Objectives	**1**	1. By nature, planning requires extensive manual effort. 2. The process utilizes a Pennsylvania-defined methodology for annual review that includes gathering information from all leadership in; the PME, PMA, and other Pennsylvania agencies with obvious connections to Medicaid. 3. This process follows established guidelines that are	**2**	1. Pennsylvania uses tools to gather, record, analyze, formulate, communicate, and distribute information on goals and objectives to Commonwealth leadership and other Commonwealth agencies. 2. The task can now be completed in less than one month. 3. Some automated workflow capabilities, standardization of data within the PME, and improved data analysis tools are

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		difficult to modify. 4. The entire process, information gathering to staff distribution, takes approximately 3 months to complete. 5. Pennsylvania-defined methodology provides guidance as to the level of detail necessary to complete the process. 6. The information is readily available through electronic storage and is updated monthly to ensure accuracy. 7. The process is thorough and stakeholder engagement is generally mandatory. 8. The process may be very slow.		used to gather, record, analyze, formulate, communicate, and distribute information on goals and objectives. 4. Continued improvement in collaboration across the PME includes the adoption of data standards to improve the information available to the process. 5. State of the art performance measures and reporting has been developed. 6. Availability of information continues to improve via data standardizations and automation. 7. Goals and objectives are, clear and more useful and can be easily traced throughout the organization to ensure that the activities of the organization match the goals and objectives.
PL02 Maintain Program Policy	**1**	1. Process is exceptionally manual, relying on use of paper documents requiring numerous manual interventions to complete. 2. Agency does collaborate with other departments or external entities as appropriate. 3. This is a very manual process and a review may take weeks to more than 4 months to complete. 4. Pennsylvania has begun to centralize some functions and automate some of the documentation needed for this process. 5. The complexity of the program(s), multiple data sources, and the requirement to manually research, interpret, and validate information impacts data access and the accuracy of the data. 6. Stakeholders are directly impacted by the timeliness, accuracy, and completeness of this process.	**2**	1. A workflow tool has been implemented to increase the efficiency and cost effectiveness of the process. 2. Automation and tools are used to gather, record, communicate, and distribute information to the PME. 3. The PME gathers information from all leadership in the Medicaid agency. Some other Commonwealth agencies are asked to provide input to the development of the Medicaid program policy. 4. Implementation of standard methodologies introduces the more frequent review and modification of program policy. This also supports traceability throughout the organization to ensure that the activities of the organization match the program policies. 5. Some automation of the information gathered for development and maintenance of program policy improves accuracy. Standard methodologies define sources for the information needed to develop and maintain program policy. The information gathered

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
				is up-to-date and more accessible.
PL03 Maintain State Plan	**1**	1. Process is exceptionally manual, relying on use of paper documents requiring numerous manual interventions to complete. 2. Once the State Plan Amendment (SPA) is initiated, the current process appears to meet all necessary timelines and submission goals. 3. The State-level groups involved in SPA development generally work well. The timelines and protocols are established and able to be tracked via work plans. 4. Average process time is between 4-6 months. 5. While paper is still involved in the update process, some output from the process is under configuration and version control on the Pennsylvania Portal. 6. Stakeholders do not lack confidence with the process.	**2**	1. The electronic State Plan system (MACPRO) has been implemented by CMS. 2. The Commonwealth Agency executive offices still rely on manual processes and paper document reviews as part of the internal approval/signoff process. 3. The Commonwealth uses an automated workflow tool to automatically route proposed changes to expedite the review process. 4. The PME has implemented intra-agency collaboration and external entity interfaces to centralize all data necessary to maintain the State Plans. Local interface rules are used. Standard procedures and shared functionality has been implemented. 5. The average process time has been reduced. 6. Process data input and results are electronic. The process is under configuration and version control in a central location available to all authorized parts of the PME. 7. The PME has implemented processes in some areas to track stakeholder satisfaction, expectations, and priorities. Improvements are made strategically, increasing stakeholder satisfaction.
PL04 Manage Health Plan Information	**1**	1. The process is primarily automated with very few manual steps. 2. The data is received electronically, but in most cases must be manually evaluated. 3. Some files are exchanged in non-standard formats. HIPAA privacy requirements are followed. 4. The system changes take a significant amount of time to implement. The existing systems do not easily support changes benefit plans.	**2**	1. A mix of nationally recognized and state-specific standards has been adopted. 2. The PMA has collaborated with other agencies and entities to adopt HIPAA standards and EDI transactions. 3. The use of automation has improved the timeliness of the process. 4. Use of COTS products and tools dramatically improves the turnaround time to produce program information. Since business staff is able to perform some of their own inquiries,

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		5. Stakeholder satisfaction is negatively impacted by the length of time it takes to implement system changes.		timeliness is generally improved. 5. Cost-effectiveness, efficiency, and accuracy of results improve through the use of automation and implementation of HIPAA data standards across the PME. Many business areas can manage many of their own inquiries 6. The PME has implemented processes in some areas to track stakeholder satisfaction, expectations, and priorities. Improvements are made strategically, increasing stakeholder satisfaction.
PL05 Manage Performance Measures	**2**	1. Commonwealth produces performance measure reports on the internet. Consumers have comparative plan between the MCO plans in their enrollment package. 2. Nationally recognized standards are in place for the MCOs. 3. The data warehouse contains data for multiple systems that is refreshed at scheduled times. 4. Many reports are scheduled at predetermined intervals. 5. Accurate reports allow program offices to make appropriate decisions about their programs and initiatives.	**2**	1. The PMA has developed automated, state of the art performance measures and reporting. 2. CI-HIE has been developed. 3. PMA periodically evaluates operational business processes against established intrastate SLAs and Key Performance Indicators (KPIs). When PMA does not meet targets, creates and executes a Plan of Action with Milestones (POAM). 4. Reporting capacity including data pulls, details, and definitions has been improved.
PL06 Manage Health Benefit Information	**1**	1. The data is received in HIPAA standard transactions. 2. The system changes take a significant amount of time to implement. The existing systems do not easily support changes to benefit plans. 3. Information required for maintenance of existing benefit packages is readily available and current. 4. Changes for plan benefits are difficult due to costly system change orders. 5. The process is accurate but lacks system flexibility to quickly implement benefit plan changes. 6. At times, benefit plan changes must be coded into the	**2**	1. Business intelligence tools have been developed to analyze data to support maintenance of the health benefit packages. 2. A mix of national and state standards is in use. 3. There is more flexibility in the structure of benefit packages, though benefit packages cannot be shared across all programs. Increased automation of analysis, standardization of data and, improvements in systems that support and/or use benefit information facilitates prompt maintenance of the benefit packages and greater ability to track the impact of changes. 4. More automation of workflow capabilities, increased

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		systems. 7. Stakeholder satisfaction is negatively impacted by the length of time it takes to implement system changes.		availability, and use of data analysis tools and standardization of data reduces inaccuracies and improves the efficiency with which decisions are reached. 5. Changes to health benefit information require little to no programming which decreases cost and improves timeliness to implementation.
PL07 Manage Reference Information	**1**	1. The process is complex and labor intensive. The Preferred Drug List (PDL) status is transmitted electronically weekly from the PDL contractor with manual verification. New National Drug Codes (NDCs) are loaded into the PROMISe™ system from the national drug compendia with manual drug coverage determination. Changes are difficult to accommodate. 2. The review of ClaimCheck® settings is a manual process. 3. Certain portions of the process is highly automated 4. The MCO area is highly automated. 5. HIPAA standards are used for medical services. 6. The processes have been improved and established standards and timelines which has increased stakeholder satisfaction.	**2**	1. Common processes have been centralized to achieve economies of scale. 2. Automation improved the process and allows staff to focus on exception resolution, increasing cost effectiveness ratio. 3. Simplify and automate using user configurable screens to create and manage healthcare benefit plans. 4. Policy Development involves the interaction with other departments. 5. Policy Development has been integrated with operational improvements to ensure that new policy is achievable. 6. User configurable business rules have been implemented.
PL08 Manage Rate Setting	**1**	1. PMA uses a mix of manual and automated processes to accomplish tasks. 2. Data analysis tools are currently used to generate reports for manual analysis. 3. The process can take 1 day to several months to complete. 4. The manual operation contains non-standard data, fragmented access, and subjective results. 5. Rate setting process is unique to each program office. 6. Pending information and delays in the decision and approval process can negatively impact timeliness. 7. When rates are not timely a	**2**	1. The process is a mix of manual and automated activities that are supported by information received electronically, from multiple sources. 2. Increased automation including automation of workflow capabilities shortens the time required to complete rate setting functions. 3. OLTL uses a mass rate adjustment tool for waivers. 4. Accuracy and consistency of data used in the process improves due to increased automation in the exchange of data and implementation of HIPAA and other data standards

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		mass adjustment process is used to make the proper adjustments. 8. The process is not cost-effective due to labor intensive research and analysis. 9. Manual entry and validation of rates results in potential inconsistency or invalid rates. 10. In many instances, the timeliness of the process negatively impacts key stakeholder groups.		across the Medicaid enterprise. Web enabled UIs simplifies user access and improves the accuracy of manual process steps. 5. Increased availability and use of data analysis tools improves the efficiency with which research and analysis are performed. 6. Increased automation of data exchanges and standardization of data across the PME results in more accurate rates that encourage provider participation while helping to maintain cost controls. 7. The PME has implemented processes in some areas to track stakeholder satisfaction, expectations, and priorities. Improvements are made strategically, increasing stakeholder satisfaction.

3.12 Eligibility and Enrollment Management

3.12.1 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 screening (at varying levels — limited, moderate or high) for provider infractions, sanctions, exclusions, licensing, and credentials verifications. These processes share a common set of provider-related programmatic, demographic, and credentials 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.

3.12.2 Eligibility and Enrollment Management As Is Summary

Eligibility and Enrollment business processes that involve members include determining member eligibility, enrolling and disenrolling members, and inquiring member eligibility. The COMPASS system accepts 25 percent to 30 percent of all MA member applications online. Application data entry can be untimely and inaccurate due to CAOs workload and turnover. Applicant information is processed by the CIS within the Medicaid Enterprise. CIS is made up of six subsystems that support application processing (AP) and eligibility determination. Medicaid recipient eligibility, managed care enrollment, and TPL data is maintained in CIS. The MMIS accesses CIS databases in real time to obtain data to support claims processing activities. Batch files are also exchanged between the systems. While the receipt of enrollment

and disenrollment data is fully automated, the processing of the data is siloed, e.g., HCSIS and CAOs. Increased manual intervention is required to correct the data inconsistencies, resulting in delays in members' access to care.

The online and batch enrollment processes support approximately 2.7[11] million recipients. There are daily and monthly electronic files that are sent to the MCOs, the enrollment broker, MATP contractor, radiology vendor, actuarial contractor, and PROMISe™. The systems (e.g., CIS) cannot accommodate all of Pennsylvania's business rules, exceptions to the rules, and unique situations. Frequent manual intervention is needed to correct coverage data and special request information and electronic enrollment forms submitted online require manual processing.

Numerous programs and business units within the Medicaid Enterprise perform or have a role in managing the Eligibility and Enrollment business processes that involve members. These owners include, but are not limited to:

- DOH
- DMVA
- DPW
  - OA
    - BIS
  - OCDEL
  - Office of Communications
  - ODP
  - OIM
    - CAOs
  - OLTL
  - OMAP
    - BMCO
    - BDCM
    - BFFSP
    - BPAP
  - OMHSAS
- Governor's Office of Administration
  - OIT
    - PDA
    - PDE
    - PID
  - CHIP
    - SSA

Other:

- Medicaid Providers
- Medicaid Managed Care Enrollment Broker
- Philadelphia HHS – Division Department of Health Human Services (District 51Y)

Eligibility and Enrollment business processes that involve providers include determining provider eligibility, enrolling and disenrolling providers, and inquiring provider eligibility. Several other programs have a role in other processes associated with these business processes. In Pennsylvania, a medical provider is required to enroll in the program and must meet all applicable national, federal, and state

[11] PA ACA IAPD

licensing and credential requirements. Requirements by provider type are available at: http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/enrollmentinformation/index.htm.

Currently in Pennsylvania, approximately 20,000 enrollments are processed per year. The various systems used to process provider applications are PROMISe™, Provider Enrollment Automation Project (PEAP), ePEAP, MEDICHECK, EDW, FADS, Local Microsoft Access Database, and Statistical Analytical System (SAS).Many file extracts or manual checks are used for screening from State and Federal Databases including, but not limited to The OIG MED, PA DOS License File, LEIE, EPLS/SAMS, CMS Certification, National Plan and Provider Enumeration System (NPPES), Clinical Laboratory Improvement Amendment (CLIA) Certificates, Pennsylvania DOH and DPW License, and other state background checks.

Business units within the Enterprise that have ownership in Eligibility and Enrollment business processes that involve providers include but are not limited to:

- DOH
- DMVA
- DPW
  - OA
  - OCDEL
  - OCYF
  - ODP
  - OLTL
  - OMAP
    - BMCO
    - BDCM
    - BFFSP
    - BPAP
  - OMHSAS
- PDA

Review of the Pennsylvania Eligibility and Enrollment Management business area indicates the As Is Capability Maturity Level is currently determined to be at a Level 1. The primary factors affecting maturity ratings across the Eligibility and Enrollment Business Area include the following:

- A mixture of automated and manual business processes
- Manual intervention is required due to contractual and unique rules and processes that often reduce the effectiveness of the automated processes
- Timeliness, efficiency, accuracy, and cost effectiveness are impacted by the manual processes
- Data validation and verification is primarily a manual process
- Ongoing, manual data manipulation during various steps of the processes affects the cost-effectiveness of this process
- Stakeholder satisfaction is not actively measured in all areas

3.12.3 Eligibility and Enrollment To Be Summary

As established during the Commonwealth's EVS, and as a result of the upcoming implementation of the ACA, this business area is considered a high priority. This business area will advance in Maturity Level as system changes and enhancements relevant to the ACA are implemented.

The Commonwealth will focus on ACA compliance, using a model and approach which complies with 7C&S. Focusing on modularity, the Commonwealth will leverage the existing systems to accommodate the required upgrades.

The Pennsylvania goals for Eligibility and Enrollment, as determined by the Executive Leadership are pertaining to members include the following:

- Enhanced the use of the MCI
- Provide secure, web-based assessment tool for OLTL functions
- Provide online, web-interface data submission from assessment tools to enable real-time eligibility determination and enrollment for all programs in the Commonwealth
- Provide comprehensive online member and case management
- Provide program integration through collaboration with other entities
- Ensure that information is available to the client via a Personal Health Record
- Ensure that client eligibility and enrollment data is available across all programs
- Eliminate duplicate information and processes and implement a one-stop shop system across all departments
- Support reuse and (authorized) sharing of information

Additional primary functional capability improvements across the business area as it pertains to members include the following:

- Enhanced the use of the MCI. Enhancement will include establishing governance for business, technology, and information to manage the ongoing use and updates to MCI. This governance will include agency of record and system of record for contradictory data.
- Provide secure, web-based assessment tool for OLTL functions
- Provide online, web-interface data submission from assessment tools to enable real-time eligibility determination and enrollment for all programs in the Commonwealth
- Provide comprehensive online member and case management.
- Provide program integration through collaboration with other entities
- Ensure that information is available to the client via a Personal Health Record
- Ensure that client eligibility and enrollment data is available across all programs. This will begin with meeting with stakeholders, building common approaches, and addressing any cultural or program silo issues prior to expansion plan. This must also include real time interfaces with other entities such as Supplemental Security Income (SSI), vital statistics, etc.
- Eliminate duplicate information and processes and implement a one-stop shop system across all departments
- Supports reuse and (authorized) sharing of information
- Address business process workflow as a project to ensure all eligibility intake processes can be met by the system. The workflow functionality must support flexibility while enforcing business rules across various programs. Automated triggers and notifications must be included as part of workflow.
- Simplify the UI to reduce training time and level of complexity. This will include a help for common questions and useful notifications for system updates.
- Develop an enterprise data model to support all future system development and enhancements early in the project planning process. This data model must support the comprehensive needs of the enterprise including member, provider, claims, PA, and case management.
- Ensure self-service functionality to members, which include information about that program. Member portal must also include detailed status notifications for the application process. Integrate text message and other functionality to enhance communication with the member. Functionality should

include the ability for members to update data that would then pond for approval. Self-service data modification functionality must be role based.
- Ensure the member portal supports role-based security to determine access. Functionality must also include the ability for the member to identify users to grant full access to the health record, program information, and other account data.
- Recognize that CAOs' need more case workers; case workers need more training and more accurate/automated business rules will reduce errors
- System integration to support member management process must consider current contracts, what makes sense for workload, and making changes in a reasonable manner
- Review the data and interface requirements with MCOs to fine tune interface requirements and applicant status. In cases where SSA is not prompt on sharing data back on closing cases, system jobs should be modified to take into account role, timeliness, and other user configurable business rules to minimize case issues. This could be a policy issue, a process issue, or a system issue. Leverage existing policy and legislature to take advantage of available data resources (digital object identifier (DOI), carrier files, etc.) across departments, states, commercial, and public.
- Expand the use of the 270/271 to as close to 100 percent of all inquiries as possible
- Incorporate DOH eligibility into CIS

Capability improvements for this business area which pertain to providers are:

- Enhance the use of clinical messaging throughout the Medicaid Enterprise
- Enhance the MPI and its usage throughout the Enterprise. This enhancement must include meeting the broader definition of a provider, providing web-enabled access for all programs and regions, and include a data model that supports the data needs for all programs. This resource must provide a single point of entry for all providers in Pennsylvania. The data model must accommodate identifying providers who are also contractors of other services. The MPI must integrate to other information sources to propagate other known data. This is a priority project and the enhancements should be targeted within the 5-year period.
- Enhance the MPI to include the ability to geographically assess the provider network
- Eliminate barriers to improvements such as Commonwealth regulation requiring "handwritten" signatures. The current goal for all enrollments is to transition into electronic signatures.
- Implement one-stop-shop for provider electronic enrollment with automated screening and actionable output. Integrate this resource with other web applications or data sources to propagate data. Integration with federal and other state sources must be considered, especially from a constraint standpoint. The system must support active data monitoring and analysis to proactively identify anomalies.
- Implement an all-payer database. This information needs to be integrated to the MPI
- Improve the ability to effectively and efficiently communicate with providers
- DESIGN—Assist providers in reaching and demonstrating meaningful use
- Establish governance for all MITA-related improvements.
- Add additional automated databases and increase frequency of checks and exchanges
- Utilize federal and state databases available (and acquire access to others required by mandate, but not yet available) for more than just a single transaction query at a time, as well as an interface with those databases
- Enhance the use of automated messaging throughout the Medicaid Enterprise
- Implement one-stop-shop for real time dissemination of providers to all applicable entities e.g., the ability to notify members, and other stakeholders of a provider's termination via text messaging, and sending web links
- Notification of intent to disenroll to automatically be distributed to all applicable entities

- Improve the ability to effectively and efficiently communicate with providers regarding revalidation of credentials. Take advantage of automated system jobs to disenroll providers based on information received from other integrated data sources.
- Allow electronic signatures
- Assess and expand current commercial and public resources that are analyzing and maintaining provider data. Explore funding and contractual opportunities to utilize and support the PME.
- Explore and expand on the EDW, FADS, and other data repositories to meet user needs

The graph below provides an illustrated summary of the As Is and 5-Year MITA maturity goals for this business area.

Figure 15: Eligibility and Enrollment Management Maturity Level

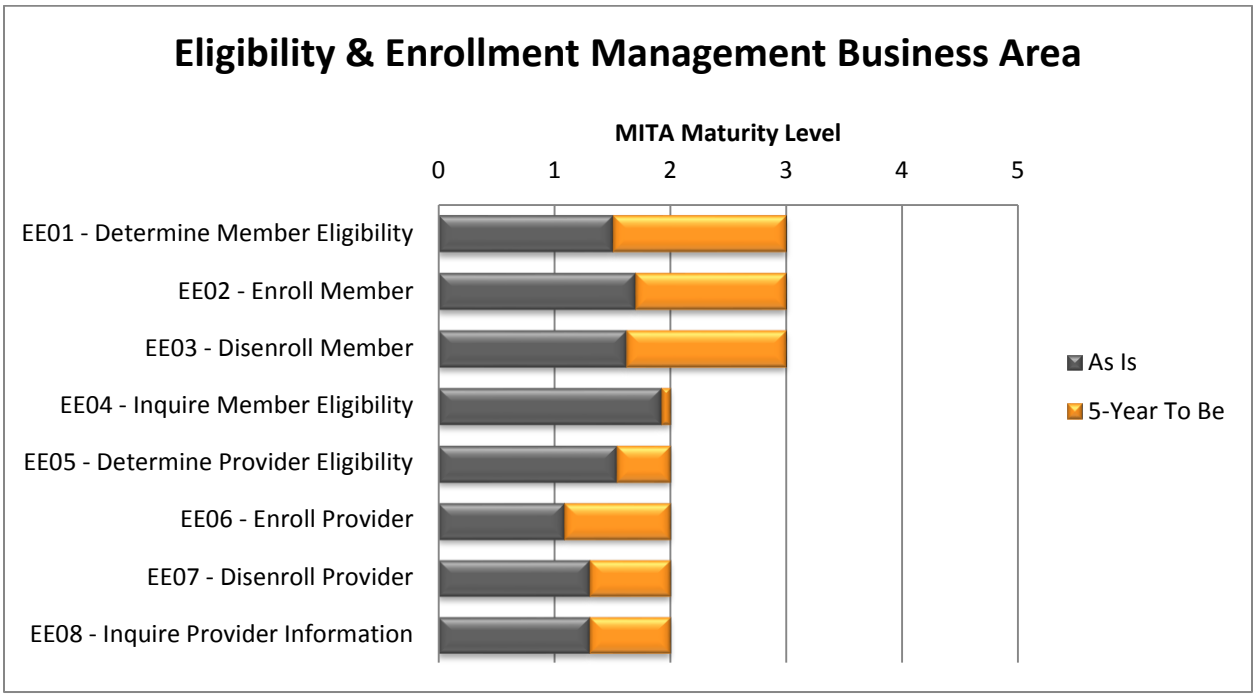


Table 13: Eligibility and Enrollment Management Maturity Summary

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
EE01 Determine Member Eligibility	**1**	1. The business process meets state and federal requirements for timely AP. 2. Application data is standardized. A consolidated "Determine Eligibility Process" manages all categories. The initial gathering of information from the applicant may be manual and inefficient. Pennsylvania Medicaid does its own eligibility (CIS). Entries can	**3**	1. State and federal requirements for accurately and timely processing of member applications are exceeded through the incorporation of one-stop collaboration across the intrastate. 2. At this level, the PMA will have automated processes to the full extent possible across the intrastate. 3. Workflows throughout the intrastate are adopted at this

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		be done from home with access to COMPASS – 25%-30% of all applications are coming in through COMPASS. 3. The formalized process ensures proper reviews for correctness and legality. 4. Data entry for HCSIS is about 5 minutes per consumer when all information is available on the template used. Time to complete Eligibility Determination Process is about 30 days. 5. The process is heavily dependent on the accuracy of the data provided and the verification process. Automation reduces the potential for additional process errors. 6. Continued application of automation has resulted in a reduced number of staff and has increased efficiency and cost effectiveness. 7. The data utilized from other agencies is readily accessible and accurate. The data provided by applicants may be inaccurate, difficult to obtain, and may require manual intervention. 8. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		level. Relevant information is transferred electronically. 4. The gathering of information from the applicant becomes more automated and efficient. More entries are coming through COMPASS. Many application data validations are automated (SSA, address, birth certificate, etc.) and consistency improves with automation of more processes. 5. Intrastate and federal collaboration improves timeliness and accuracy of the business process. 6. Automation improves the reliability of internal information and external information gathering is improved through information exchange. 7. Automation of business rules for eligibility determination continues to improve the effectiveness of the process and allows staff to focus on difficult cases. 8. Information in the member data store is instantly accessible and conforms to business rules. However, external validations may still be via phone, fax, or USPS and is subject to errors. 9. Pennsylvania will implement a member portal that supports stakeholder interaction and allows for strategically managing improvements.
EE02 Enroll Member	**1**	1. Application process is more automated. Some applications may be submitted on paper via telephone, or web-based. 2. The Pennsylvania enrollment process is over 50% automated and allows for efficient coordination of services and inter-agency collaboration. 3. Each managed care online transaction in CIS takes a second or less. There are approximately 40,000 managed care transactions in	**3**	1. Tasks are automated to the full extent possible across the intrastate. 2. Workflows ensure accuracy and proper reviews for legality. 3. Industry and other national standards are adopted across the intrastate, thus improving efficiency and the cost effectiveness to perform tasks. 4. Collaboration with other agencies to adopt standards and formalize the process increase the reliability and accessibility of internal and external information used in the

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		CIS a day. A batch enrollment/disenrollment file is processed and sent to the enrollment broker in about 75 minutes. 4. The enrollment data is partially standardized and the use of the HIPAA transaction without cross-walking (834) is used when applicable. 5. Automation and standardization facilitate accuracy. Inclusion of waivers in the enrollment automation process broadens the level of services to recipients. 6. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		business process. 5. Stakeholder satisfaction improves to 90% or higher and the PMA uses surveys to collect information.
EE03 Disenroll Member	**1**	1. Mostly automated process with little manual intervention required only in unique situations. 2. Many transactions are the result of online actions performed in CIS, while other transactions are the result of the processing of a weekly batch file sent by the enrollment broker. Some transactions are done manually in CIS as well. Updates are made to CIS and sent to PROMISe™ and the managed care plans via 834 files. 3. Daily file transmission within the PME takes about 8 hours. Weekly file transmission takes about 1 hour 15 minutes. Processing time for a monthly capitation file from start to finish is about 5 hours. 4. All data is electronic, current, and readily accessible. Accuracy rate is above 90%. 5. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.	**3**	1. Processing disenrollments exceeds state and federal requirements for timeliness and accuracy. 2. One-stop collaboration among entities occurs across the intrastate. 3. Business rules are automatically applied and used statewide; the business rules are separate from core programming and made available in human and machine readable formats. 4. The use of workflow ensures that accuracy and proper reviews occur. Standard messages are used among the intrastate. 5. Information is standardized and exchanged among the intrastate. 6. Processing time and error rate decrease and efficiency increases as automation and collaboration occurs. 7. Timeliness, access to data and accuracy improves through standardization, collaboration, and the use of industry standards. 8. Stakeholder satisfaction increases to 90% or higher.
EE04	**1**	1. All of Pennsylvania eligibility	**2**	1. Automation of information

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
Inquire Member Eligibility		information comes from a single source. Automation includes AVRS, POS, Web portal and EDI/Virtual Area Network (VAN)/Batch. High degree of automation and standardization lead to accurate results. 2. The process is formal across the PMA and both HIPAA and state standards are used to monitor compliance thresholds. Proper reviews ensure correctness and legality. Accurate logs of activities are maintained. 3. This is only a manual process until the phone number is received and verified. After that point, the data is entered and if all tests are accurate – the information is sent live, based on the effective date of the change. 4. Process duration is approximately 3 to 5 seconds – for 270/271. The other 2 eligibility inquiry methods – Provider Electronic Solutions (PES), AVRS. The time it takes to update EVS is based on outside entities (i.e., obtaining the updates from the county/plan, sending the information and verifying the information to assure accurate data, etc.). 5. Changes to business rules as well as maintenance are labor intensive. 6. The PMA collaborates with other agencies to adopt HIPAA standards, which reduce errors, improve accuracy and efficiencies. 7. Pennsylvania does not monitor and/or solicit satisfaction from stakeholders as described for this business process.		collection increases the reliability of Pennsylvania's internal information. 2. Decision making is automated using business rules. 3. Information is obtained and exchanged easily with intrastate agencies. Accessing information takes 5 seconds or less and accuracy is rated at 90% or greater. 4. Automation and standardization provides clear and useful information, thus improving stakeholder satisfaction.
EE05 Determine Provider Eligibility	**1**	1. The PMA exceeds state and federal requirements for processing applications timely and accurately. 2. A mix of standard and	**2**	1. At this level, requirements for timeliness and accuracy are routinely exceeded. Enrollment applications are processed in a one-stop shop.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		automated tasks is used to accomplish tasks, using a mix of HIPAA and state-specific standards. 3. Standard applications are used and enrollment records are stored in a single provider registry and can be accessed by providers and enrollment staff. 4. Paper and web applications are screened using a mix of federal and state screening requirements. Credentials are verified manually by Commonwealth staff. 5. The NPI is cross referenced to the Commonwealth identifier. 6. Periodically, the PMA reenrolls providers and revalidates credentials. 7. Very little collaboration occurs with other agencies to standardize tasks or information exchange. Most information is manually verified by telephone, facsimile, or mail. 8. Timelines to receive a complete application (to include supporting documentation) vary and are controlled by actions of the applicant and at times other outside agencies. The enrollment time after receipt of a completed application may take from 7-30 days. The PMA has a 30-day target for processing enrollments and achieves this target 97% of the time. 9. The accuracy and accessibility of data is subject to manual errors. 10. The manual process is time consuming and cumbersome from the providers perspective.		2. This business process will be fully automated to the extent possible within the intrastate. The majority of applications will be received online. 3. An intrastate exchange of information using standard — enrollment industry standards will be used for the exchange of information. 4. Federal screening requirements for low, medium, and high risks providers will be adopted within the intrastate. 5. Legacy provider numbers are retained for some business processes; however, the NPI is the identification of record for all but atypical providers. Only atypical providers are enumerated differently. 6. The PMA will be using standard messages and national standards within the intrastate. Standardized business rules ensure consistent validation of credentials. Revalidation of credentials is an automatic process and staff is alerted to adverse results automatically. 7. HIPAA standards and EDI transactions for information exchange and validation occurs between the PMA and other entities. 8. Improvements in automation and information sharing improve timeliness, accuracy, and efficiencies. 9. Enrollment application and items needed for verification and credentialing are easily obtained by the PMA through exchanges with intrastate agencies. 10. As efficiencies are realized through automation and exchanges, stakeholder satisfaction greatly improves.
EE06 Enroll Provider	**1**	1. The enrollment process meets federal requirements for accuracy and timeliness. 2. The enrollment process is primarily manual which	**2**	1. At this level, the PMA is routinely exceeding state and federal requirements for processing applications in a timely and accurate manner.

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		affects overall business capabilities. The applicant completes the application on paper and submits it to the PMA via facsimile, mail, or in person. 3. The Commonwealth focuses on meeting compliance thresholds for state and federal regulations. The manual nature of the business process impacts timeliness and accuracy. 4. Accessibility to the information used in the process is stored in disparate systems and must be obtained manually. 5. The process is labor intensive and subject to error. Stakeholder satisfaction in the process is low.		2. The PMA is using a one stop shop for enrollment; automated processes occur to the full extent possible within the intrastate. The applicant may submit a standardized paper application, or can enter their application through available kiosks in government offices. 3. PMA adopts enrollment standard messages, and national standards within the intrastate. Standardized business rule definitions for consistent enrollment Provider network information is shared with HIX. 4. Enrollment information is automatically collected, thereby improving timeliness, accuracy and the cost effectiveness of the process. 5. Stakeholder satisfaction increases due to the adoption of automated enrollment processes and standard messages. Stakeholder satisfaction is measured using surveys or questionnaires.
EE07 Disenroll Provider	**1**	1. The PMA uses a mix of manual and automated processes to accomplish tasks. 2. Using state-specific standards, the PMA focuses on meeting federal and state regulations. 3. Very little collaboration with other agencies to standardize information exchange or tasks is occurring. Data sharing does exist between FFS, MCOs, and other agencies. 4. The business process is meeting mandated requirements for timeliness. 5. HIPAA standards improve the accuracy of the information used in the business process. 6. The process is labor intensive. The cost effectiveness and efficiency of this business process is hampered by the lack of	**2**	1. The disenrollment process is automated within the intrastate and shared with HIX. 2. Standard provider disenrollment interfaces and other national standards are used throughout the intrastate. 3. Collaboration with other entities increases in an effort to adopt HIPAA standards and EDI transactions. 4. The time it takes to perform the business process improves as state and federal collaboration increases. The use of provider disenrollment information sharing, regional information exchange hubs improve the timeliness to 24 hours or less. 5. Provider disenrollment information is easily obtained through intrastate exchanges based upon industry standards. 6. The cost effectiveness and efficiency of the business process improves through

MITA Business Process	As Is Maturity Level	As Is Process Description	5-Year To Be Maturity Level	5-Year To Be Process Description
		standardized, automated tasks. 7. Stakeholder satisfaction is low due to the lack of standardization and automation.		standards and automation. 7. As accuracy and efficiency improves through automation, stakeholder satisfaction with the business process improves.
EE08 Inquire Provider Information	**1**	1. Most requests are received and responded to via phone and email. Other response methods are used as appropriate. 2. The Commonwealth focuses on meeting compliance thresholds using state-specific standards. The process meets mandated requirements for timeliness. 3. Very little collaboration with other agencies to standardize information exchange or business tasks is occurring. 4. Manual responses have a higher probability of being inconsistent; HIPAA standard transactions improve the accuracy of responses. 5. Information is researched manually and may lead to inconsistencies in responses. 6. Requires high degree of manual intervention resulting in relatively low cost-effectiveness. 7. Stakeholders receive the information they need, but may lack confidence in the information.	**2**	1. Responses are submitted via AVRS, Web portal, EDI, via personal computer (PC) or terminal connection or within batch response. 2. The PMA begins to standardize HIPAA and EDI transactions in a collaborative effort with other entities. 3. Research and responses are automated which improves timeliness and accuracy. 4. The reliability and accessibility of provider inquiry information increases as the PMA automates the collection and exchange of data. 5. Automation leads to staff working exceptions only and increased cost effectiveness and productivity of staff. 6. Automation and standardization provides clear, accurate, and useful information. Stakeholder satisfaction improves.

4.0 MITA SS-A Technical Assessment Results

This section presents the results of the MITA SS-A technical and information assessment. Section 4.1 Current Systems addresses the systems that compose the current technical environment. Section 4.2 As Is TA provides assessment results in more detail than presented in the Executive Summary (Section 1.0), displaying the assessed maturity of Pennsylvania Medicaid systems relative to the technical and IA capabilities.

4.1 Current Systems

The PME is supported by a variety of systems, data repositories, and other IT assets using a host of platforms and architectures. For this technical assessment, the scope of systems included in the analysis focused on fifteen (15) primary systems supporting the enterprise. As Pennsylvania moves forward, systems may be added or removed from the assessment based on changes in strategy.

Table 14: Primary Systems Supporting the Enterprise

Primary Systems		
▪ PROMISe™ ▪ Provider Web Portal ▪ Department Web Portal ▪ Enterprise Content Management System (ECM) ▪ EDW ▪ MCI	▪ CaseNet ▪ Electronic Client Information System (eCIS) ▪ CIS ▪ SAMS ▪ HCSIS	▪ CHIP and Adult-Basic Processing System (CAPS) ▪ MPI ▪ Program Access Improving Daily (PAID) ▪ COMPASS

4.2 System Descriptions

This section briefly describes each system used to administer the Medicaid program in PA.

PROMISe™

The PROMISe™ system is a comprehensive Medicaid claims processing system that supports both the traditional FFS and managed care delivery models. HP is the Medicaid FA for the Commonwealth of Pennsylvania. The FA operates, maintains, and enhances the MMIS. The Department contracts with the FA for a wide range of services including front-end claims processing (imaging, data entry and claims resolution), automated eligibility verification, online pharmacy claims capture and adjudication including Prospective and Retrospective Drug Utilization Review (ProDUR/RetroDUR), provider and user training, drug rebate processing, ePrescribing, plastic Medicaid ID card production, a FADS, document management, financial processing including capitation payments, and various web applications.

The FA manages computer systems and networks located at multiple locations in support of the Pennsylvania MMIS. The primary operational site for the Pennsylvania MMIS is in Camp Hill, Pennsylvania.

ECM

The ECM is also known as DocuShare and provides an unstructured Data Content Management system. DocuShare is account driven and web-enabled. The ECM unit is responsible for business process re-engineering. Working with departmental staff, they assist in analyzing processes, recommend modifications and develop the automated systems to meet the user requirements and implement the

necessary changes. Document management, scanning, imaging, web content management, and workflow functions are the responsibility of this unit.

EDW

This EDW and its support unit are responsible for the development of the data warehouse schema, tables, and entities. The unit develops entity relationship diagrams, the LDM, keys, indexes, and partitioning strategies; develops the extracts to unload the data from operational sources and the mappings to cleanse and load the data to the data warehouse. The unit is responsible for all new data and monthly loads of existing data. The unit monitors performance of the extracts and loads and makes modifications as necessary. Any transformations needed to create summary tables are the responsibility of this unit. They also monitor and review all mappings developed by contractors.

Provider Web Portal

The provider portal provides a common entry point for all providers to be able to perform multiple functions (submit, inquire and adjust claims, review remittances, perform eligibility requests, and administrative functions). As a prerequisite, providers need to be enrolled in Medicaid to perform these actions. Providers are able to assign delegates (alternates and billing agents) to perform these functions on their behalf.

Department Web Portal

The Department Web Portal is an informational website supporting all the DPW programs with content. The Department staff regularly updates and publishes content to this portal to provide online access by members, providers, contractors, and other stakeholders.

MCI

The MCI is an automated, enterprise-wide client identification process that registers and identifies individuals uniquely within DPW. MCI provides a common central repository, accessible to users from various operational systems, that provides consistent and uniform client information across programs and systems. After the user has registered once, MCI provides basic information for reuse and registration Department-wide. MCI provides a consistent interface for future DPW systems to register and identify clients and it provides a mechanism to monitor how and where the client is interacting with the Department. Additionally, MCI allows for profile management. MCI enables efficiencies to be gained by the reuse of application processes and functions. It provides more reliable data due to consistent, enterprise-wide business standards.

CaseNet

CaseNet is a case management system utilized by FFS Medicaid to assist with medical management and tracking of managed recipients. Presently recipients are referred to the nurse case managers for input. CaseNet is a flexible care management component that is integrated into the medical management review process.

eCIS

The eCIS is a key component of the Integrated Client Information System (iCIS) suite. This suite supports approximately 7,000 workers and 1,000 providers at over 100 separate locations including the 102 county/district offices, and the Pennsylvania citizens who provide services or receive them. Each year, DPW uses iCIS to provide over $850 million of services through Temporary Assistance to Needy Families (TANF), Food Stamps (FS or Supplemental Nutrition Assistance Program (SNAP)), General Assistance (GA), State Blind Pension (SBP), MA, Long-Term Care (LTC), and supplements to basic SSI grants.

The iCIS suite is the backbone for the Department and supports case processing, determines eligibility, authorizes services and distributes benefits to more than one million needy Pennsylvanians. It interfaces with more than 100 entities within the state and federal government for information matching and it is the key automation vehicle for the CAOs in delivering more than 20 programs and services.

iCIS contains information on clients and their household members enrolled in cash assistance, MA, and/or food stamps programs. Information maintained includes demographics, MA and managed care enrollment history, and special populations (foster care, adoption, and SSI). CIS, the COBOL-based, mainframe-driven suite of systems (implemented in 1985), coupled with the server systems, referred to as iCIS, perform both online and batch functions and is comprised of many components; the two biggest are eligibility determination/benefit calculation and case management. It is used to determine eligibility for Medicaid, TANF, Food Stamps (now called SNAP), GA (state cash program), HCBS, LTC, and Medicaid Waiver Programs. eCIS supports 7,000 workers who regularly access the system.

Given the aging technology foundation for this mission-critical system, the Department started to incrementally refresh CIS (the mainframe component) in 2001, with the introduction of COMPASS, its online screening and application tool. Several years ago, the Department also embarked on a strategy to incrementally migrate mainframe functionality to a browser-based platform and introduce additional automation tools to help streamline OIM's business processes and to meet CMS mandates, state legislative mandates, and changing consumer needs. These new web enabled components are referred to as eCIS. Collectively, the CIS and eCIS components are referred to as iCIS.

CIS

The CIS is a key component of the iCIS suite. CIS a COBOL-based, mainframe-driven suite of systems implemented in 1985. CIS, coupled with the server systems, is referred to as iCIS, and performs both online and batch functions and is comprised of many components.

The two biggest components of CIS are eligibility determination/benefit calculation and case management. CIS is used to determine eligibility for Medicaid, TANF, FS (SNAP), GA (state cash program), HCBS, LTC, and Medicaid Waiver Programs. CIS supports 7,000 caseworkers and clerical staff who use it in the CAOs. Reprogramming it to adjust to new state and federal programs and policies is a major and time-intensive effort.

SAMS

SAMS is the core application of an integrated consumer assessment and care management system used to support the level of care determination, needs evaluation, and care management for all consumers served in HCBS by the PDA and Aging Consumers by the OLTL.

SAMS is a centralized web-based (through Citrix Access Gateway) system utilized daily by the 52 Area Agencies on Aging (AAAs) and the Nursing Home Transition Partners. Major functional areas within SAMS include intake, registration, level of care and needs assessments, service planning, service orders generation, issuance, and service delivery records. SAMS also has functionality to create service routes listing specific consumers for service providers and consumers rosters to record service deliveries for congregate service provides. Included within the care management functions are recording of case notes and journals and the scheduling and tracking of required activities for individual consumers.

SAMS also has a very robust ad hoc reporting system which supports the generation of management reports to meet mandatory local, state, and federal reporting requirements and to ensure appropriate management of consumers. SAMS is critical in the QA management to meet CMS requirements for both existing and new programs as they are developed and implemented.

HCSIS

The HCSIS was designed and built to support the DPW's HCBS Programs. HCSIS provides development and maintenance of ISPs supporting 17 federal and state-funded community based service programs. PROMISe™ provides claims processing for HCSIS and the Aging Waiver Care Plan.

CAPS

The CAPS is the automated system developed by the Department for the purpose of determining eligibility for the CHIP and for the adult Basic Program. It is comprised of eight different modules that aid the CHIP program area and its health care contractors to enroll and manage their CHIP clients. Currently there are about 195,000 kids enrolled in the program. In addition, CAPS includes a data warehouse for the purposes of storing and analyzing data for drug utilization and fraud.

MPI

The MPI is the DPW's central repository of information on providers who enroll to do business with, known to or are paid for by DPW. MPI captures information on the legal entity name, address, Federal tax-id number (Employee Identification or Social Security), provider type and specialty and the physical location at which the provider supplies departmental services. The MPI application is accessed by other Enterprise Applications (CIS, Pennsylvania Enterprise to Link Information for Children Across Networks (PELICAN), EDW, HCSIS, PROMISe™ and TPL) to validate provider information.

PAID

PAID is not a system, but a 2005 project to take several client registrations and claims payment programs to DPW systems. The Core System provides provider contract management, patient enrollment, claims adjudication, and invoice processing functionality for the Department's Bureau of Family Health (BFH). Programs supported by PAID include Chronic Renal DP, Head Injury and Newborn Screening and Formula. Some programs, such as Family Planning, Genetics, and Sickle Cell, no longer use client enrollment or claims for payment justification and are therefore no longer part of the migration effort even though they were part of the PAID project initiative.

The DOH-Bureau of Communicable Diseases uses the TB Invoicing system to perform client registration and process provider claims for TB invoices only. Sexually Transmitted Disease (STD) claims are processed via a vendor system. Healthy Woman — Cancer screening and prevention services. Program/system is handled by a vendor. HIV/AIDS is a newer program in DOH that is currently processed using a vendor for pharmacy claims and PROMISe™ for lab claims.

COMPASS

COMPASS is a website that allows authorized users to apply for and renew a broad range of social programs, including healthcare, food stamps, cash assistance, LTC, HCBS for individuals with intellectual disabilities, and Low-Income Home Energy Assistance Program (Seasonal).

In addition to the programs mentioned, COMPASS also provides screening for all home and community-based services, and the school lunch program. Screening allows a user to provide basic information to determine if they are potentially eligible for a social service. When fully implemented, COMPASS will include applications and renewals for all HCBS and child care subsidies.

4.3 As Is Enterprise Diagram

This section presents a diagram that illustrates the current Enterprise diagram of systems. The data types included in the data flows represent general data types to simplify the survey for responders. As an

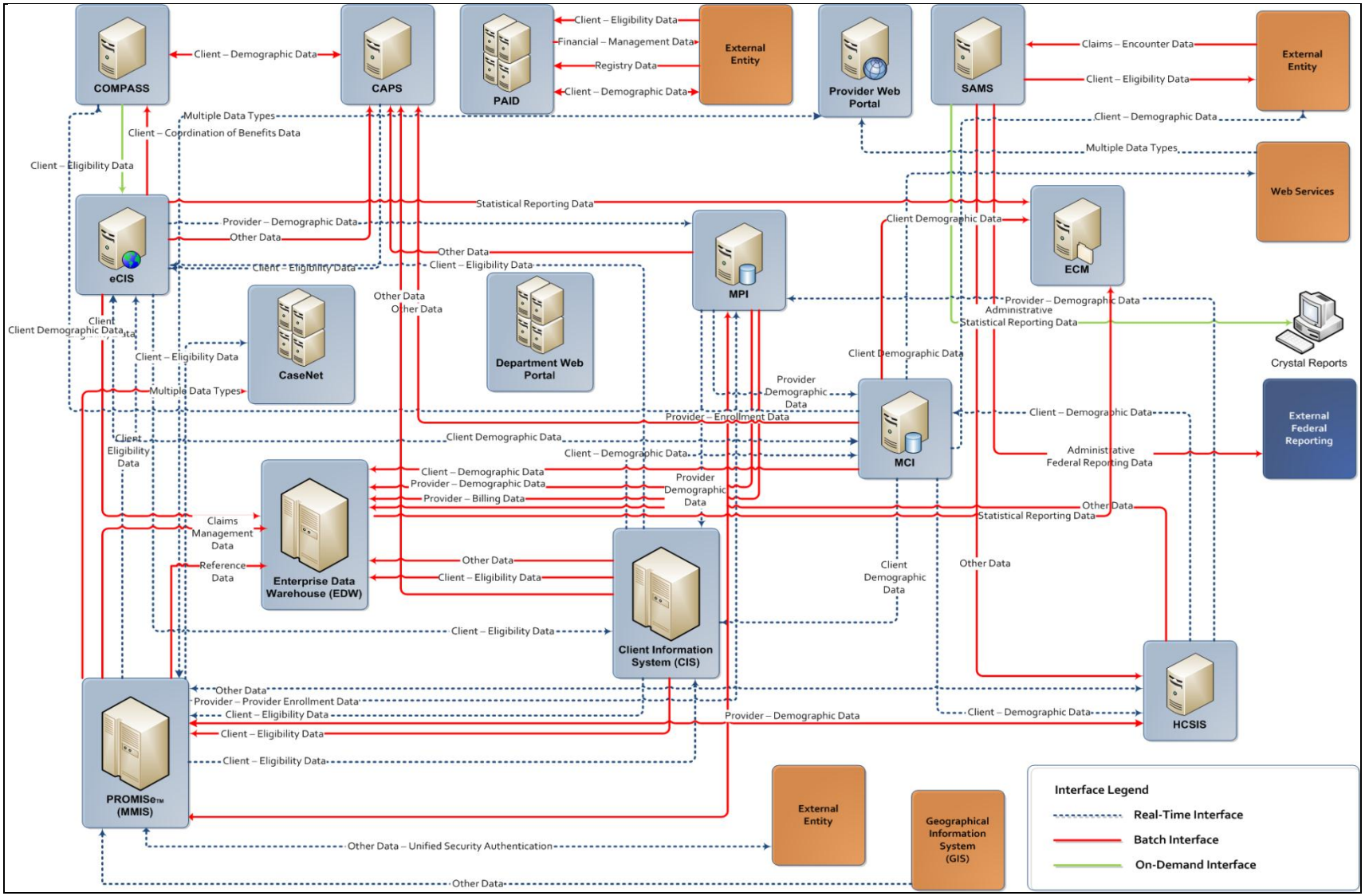
example, the Provider – Billing Data represents any provider type, specialty, location, or other data necessary to accurate process provider payments. The data types listed in this diagram include:

Table 15: Data Types

Data Types	
• Administrative – Performance Measures • Administrative – Project planning and sign-off • Administrative – Training Building Plans • Administrative – HHS Litigation • Administrative – Federal Reporting Data • Administrative – HR Management Data • Administrative – Inventory Management Data • Administrative – Program and Policy Data • Administrative – Registry Data • Administrative – Statistical Reporting Data • Administrative – Time Tracking Data • Administrative – Training Management Data • Administrative – User and Access Control Data • Administrative – Financial Management Data • Administrative – Contract Management Data	• Administrative – Background Check Data • Claims – Claims Management Data • Claims – Encounter Data • Claims – Reference Data • Client – Case Management • Client – Coordination of Benefits Data • Client – Demographic Data • Client – Clinical/Diagnosis/Lab Data • Client – Eligibility Data • Client – Enrollment Date • Provider – Billing Data • Provider – Demographic Data • Provider – Incident Reporting Data • Provider – Licensing Data • Provider – Management Data

The As Is Enterprise Diagram below provides an illustration of the current enterprise systems included in this assessment. The diagram includes each of the 15 systems or IT assets included in this assessment, the data flows between each system, and the interface type for data exchanges.

Figure 16: As Is Enterprise Diagram



A technical assessment survey was distributed in March 2013 and completed in April 2013 and its purpose was to gather specific information related to the core systems described in Section 4.1 and 4.2. The survey included 46 questions and focused on program support, architecture, software, processing volumes, data types, and interfaces. This section will provide a summary of key outcomes of this survey. Detailed response data from this survey is provided in Appendix E: Technical Survey Results.

4.4 Pennsylvania Technical Assessment Results by Technical Area

This section summarizes the results of the assessment of the As Is TA. The results for each technical function are presented in a table format. Each table contains a brief description of the MITA technical function, a description of the As Is circumstances of that technical function based on results from the twenty (20) primary systems surveyed, and a pie chart showing a graphical representation of the survey results. The maturity assessment for the technical function relative to each system is also included.

The survey results are meant to provide a basic idea of current system capabilities related to MITA functionality. However, the survey responses are provided by systems staff and may not reflect desired functional improvements outlined by the business capability assessment and MITA 3.0 Roadmap.

In order to determine the overall maturity for each capability, the CMS MITA Framework 3.0 Companion Guide (page 34) was leveraged. The guidance is as follows:

"Technical Architecture

> *The SMA must meet all the capabilities for a level before it can advance to the next level when evaluating the TA. A business process scores at a Level 3 only when the SMA achieves all technical capabilities defined for Level 3 in the TCM. CMS expects the business area to meet all criteria of the maturity level; otherwise, the business area scores at the lower capability level. A maturity level will be a whole number (e.g., Level 1, Level 2, etc.). We provide a TA Scorecard template at the end of the SS-A Companion Guide."*

For the complete set of technical survey results, see Appendix D: Technical Survey Results.

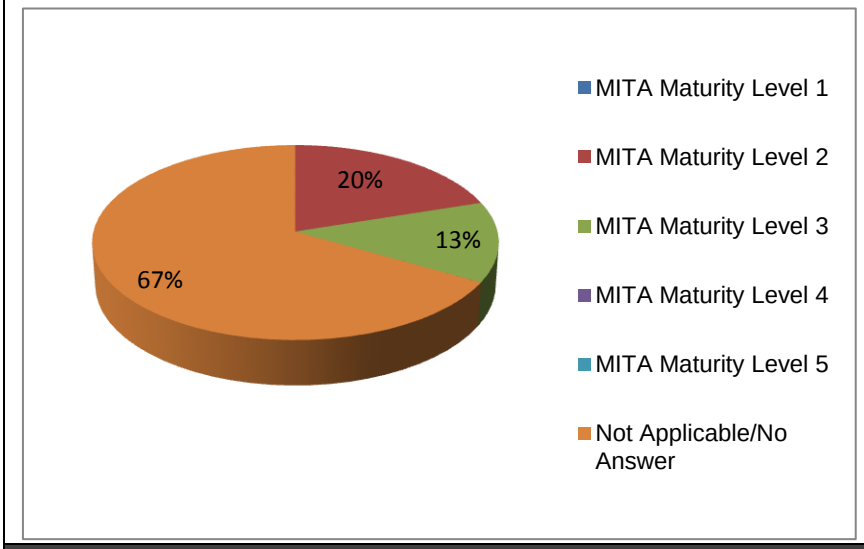
4.4.1 Member and Provider Support

This table summarizes the results of the assessment of the TA used in Member and Provider Support.

Table 16: Summary of Member and Provider Support TA

<table>
<tr><th colspan="2">MITA Technical Function and Description</th><th colspan="4">PA Medicaid Systems</th></tr>
<tr><td colspan="2">Member and Provider Support</td><td colspan="4" rowspan="2"></td></tr>
<tr><td colspan="2">The Member and Provider Support technical function focuses on the ability to access business functions using a single web-enabled access point.

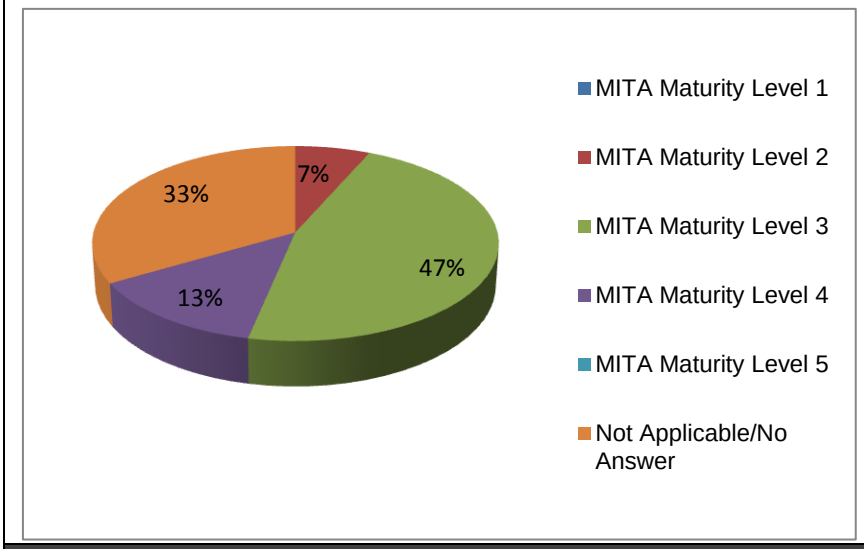
Level 1: Member and provider access to appropriate business functions via manual or alphanumeric devices.
Level 2: Member and provider access to appropriate business functions via portal with single online access point.
Level 3: Member and provider access to appropriate business functions via portal with single online access point including standard exchanges.
Level 4: Member, provider and other staff access member electronic health data online including clinical data. Data exchanged with HIE. Member access to HIX.
Level 5: National exchange of member, provider and other appropriate data. National data exchanged with HIE. Cross-region Member access to HIX.
0: Not Applicable/Did Not Answer

 
</td><td>COMPASS</td><td>2</td><td>PAID</td><td>2</td></tr>
<tr><td></td><td></td><td>MPI</td><td>0</td><td>CAPS</td><td>3</td></tr>
<tr><td></td><td></td><td>CaseNet</td><td>0</td><td>CIS</td><td>0</td></tr>
<tr><td></td><td></td><td>Department Web Portal</td><td>0</td><td>eCIS</td><td>0</td></tr>
<tr><td></td><td></td><td>ECM</td><td>0</td><td>EDW</td><td>0</td></tr>
<tr><td></td><td></td><td>HCSIS</td><td>0</td><td>MCI</td><td>0</td></tr>
<tr><td></td><td></td><td>MMIS</td><td>0</td><td>Provider Web Portal</td><td>2</td></tr>
<tr><td></td><td></td><td>SAMS</td><td>3</td><td></td><td></td></tr>
<tr><th colspan="6">Assessment of Member and Provider Support</th></tr>
<tr><td colspan="6">According to the survey results, the Member and Provider Support technical service is only applicable to about 33% of the Medicaid systems assessed. Of the systems surveyed, the vast majority have indicated that this service does not apply to them. For the systems this applies to, it is important to focus on consolidating these systems into as few portals as possible to make the experience less fragmented for Member and Provider User groups. Also, standards for access, layout, format, and navigation should be considered for all PME access points to promote intuitive use by stakeholders.</td></tr>
</table>

4.4.2 Business Intelligence

This table summarizes the results of the assessment of the TA used in Business Intelligence.

Table 17: Summary of Business Intelligence TA

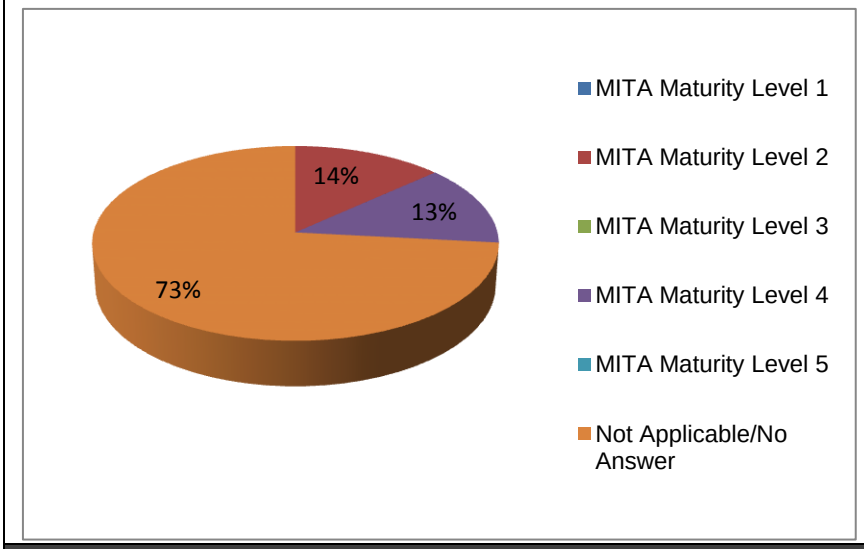
MITA Technical Function and Description	PA Medicaid Systems			
Business Intelligence				
The Business Intelligence technical function focuses on the ability to capture, manage, and report functional data. *Level 1: Business intelligence information available by custom-coded programming.* *Level 2: Business intelligence information is inconsistent and unreliable with very little automation.* *Level 3: Business intelligence information is available for specific business functions. The State Medicaid Agency (SMA) limits access to a small group of stakeholders.* *Level 4: The SMA adopts strategic business intelligence environment with defined governance policies and enforcement. Business objectives drive business analysis and performance management strategies. The SMA adopts enterprise-wide performance standards and metrics for business analysis.* *Level 5: The SMA adopts business process specific performance standards and metrics for business analysis. The SMA performs behavior simulation and prediction modeling on large populations. The SMA shares business analysis with providers, beneficiaries, and trading partners.* *0: Not Applicable/Did Not Answer*  	**COMPASS**	**2**	**PAID**	**3**
	MPI	**0**	**CAPS**	**4**
	CaseNet	**3**	**CIS**	**3**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**0**	**EDW**	**4**
	HCSIS	**3**	**MCI**	**0**
	MMIS	**3**	**Provider Web Portal**	**0**
	SAMS	**3**		
Assessment of Business Intelligence				
The Business Intelligence technical function is primarily level 3 in the systems assessed in Pennsylvania, but 33% say it does not apply. As Pennsylvania improves MITA maturity in this area, the Commonwealth should focus on standard business intelligence metrics and consolidating data into a single or centralized dashboard. Pennsylvania would benefit from having business intelligence information available and standardized enterprise-wide.				

4.4.3 Forms and Reporting Management

This table summarizes the results of the assessment of the TA used in Forms and Reporting Management.

Table 18: Forms and Reporting Management TA

MITA Technical Function and Description	PA Medicaid Systems			
Forms and Reporting Management				
The Forms and Reporting Management technical function focuses on the ability to receive data via an electronic interface or web form. *Level 1: Direct data entry from paper forms.* *Level 2: Data entry using electronic forms. The SMA produces reports with manual data entry and processing.* *Level 3: Online electronic forms accept limited file type (e.g., txt, xls, or Portable Document Format (pdf)) attachments. The SMA adopts periodic submission of electronic reports.* *Level 4: The SMA adopts real-time submission of claims, clinical, and other reporting information.* *Level 5: Real-time national database with regional, state and local reporting information.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**2**	**PAID**	**0**
	MPI	**0**	**CAPS**	**0**
	CaseNet	**0**	**CIS**	**0**
	Department Web Portal	**0**	**eCIS**	**2**
	ECM	**0**	**EDW**	**0**
	HCSIS	**0**	**MCI**	**0**
	MMIS	**4**	**Provider Web Portal**	**0**
	SAMS	**4**		



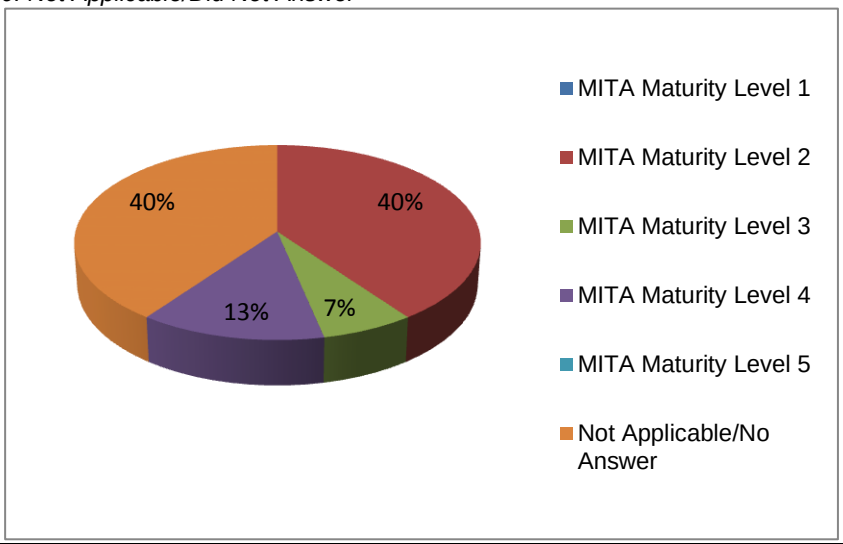
Assessment of Forms and Reporting Management
The Forms and Reporting Management technical function is felt to be not applicable to 73% of the systems surveyed, while the MMIS and SAMS believe themselves to be at a level 4. Any types of forms and submissions should move to being electronic and real-time to ensure increased efficiency.

4.4.4 Performance Measurement

This table summarizes the results of the assessment of the TA used in Performance Measurement.

Table 19: Performance Measurement TA

MITA Technical Function and Description	PA Medicaid Systems			
Performance Measurement				
The Performance Measurement technical function focuses on the ability for this system to collect and report program performance data based on user-defined criteria. *Level 1: Manual calculation of performance standards in spreadsheets.* *Level 2: Collect and report using predefined and ad hoc reporting methods and state defined performance standards.* *Level 3: Define, implement, collect, and report using a set of business process–related performance standards that conform to federal metrics.* *Level 4: Produces automatic system alerts and alarms when performance metric is not within defined performance standard.* *Level 5: National use of performance standards and alerts for variances not within defined performance standard boundaries.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**2**	**PAID**	**0**
	MPI	**0**	**CAPS**	**2**
	CaseNet	**2**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**2**
	ECM	**0**	**EDW**	**0**
	HCSIS	**2**	**MCI**	**0**
	MMIS	**4**	**Provider Web Portal**	**4**
	SAMS	**3**		



Assessment of Performance Measurement

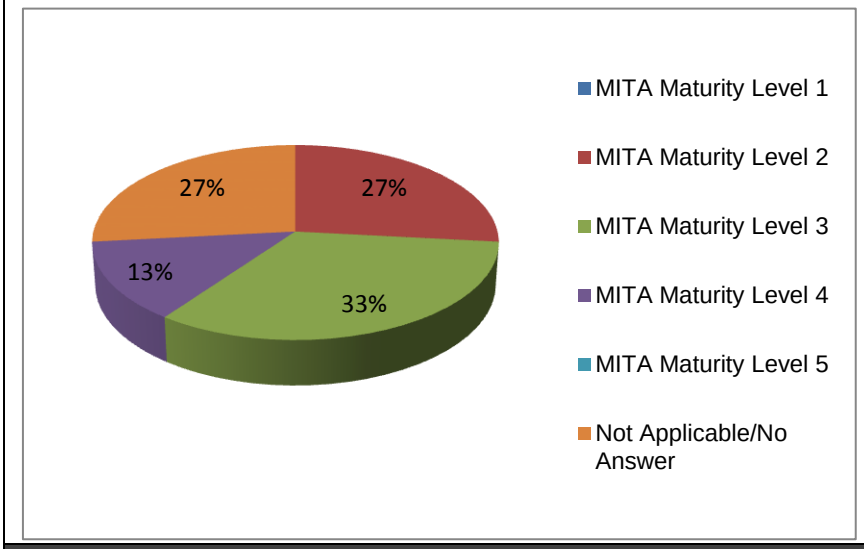
The Performance Measurement technical function is varied across the assessed systems in Pennsylvania. About 60% of systems capture and provide reporting capabilities for performance measurement. Of those, 40% believe to be at level 2 and 13% at level 3. As Pennsylvania progresses in MITA maturity, the focus should be on standardizing these performance measures based on federal metrics and expanding the ability to look across multiple systems for efficiency.

4.4.5 Security and Privacy

This table summarizes the results of the assessment of the TA used in Security and Privacy.

Table 20: Security and Privacy TA

MITA Technical Function and Description	PA Medicaid Systems			
Security and Privacy				
The Security and Privacy technical function focuses on the ability of the asset to maintain secure access to information to authorized users. *Level 1: Beneficiary and provider access to services via manual submission, alphanumeric devices (i.e., paging), or ED). The SMA uses policy and procedures controls to ensure privacy of information.* *Level 2: Provides member and provider access to services via browser, kiosk, voice response system, or mobile phone.* *Level 3: Provides member and provider access to services online via mobile device. The SMA supports automatic user authentication. The SMA provides staff with Single Sign-On (SSO) functionality to a majority of the applications in the State Medicaid Enterprise. The SMA restricts access to data elements based on defined access roles.* *Level 4: Provides user authentication via SecureID tokens and delivery of results to authentication and authorization functions.* *Level 5: Provides user authentication via biometric identification and delivery of results to authentication and authorization functions.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**2**
	MPI	**0**	**CAPS**	**2**
	CaseNet	**3**	**CIS**	**3**
	Department Web Portal	**0**	**eCIS**	**2**
	ECM	**4**	**EDW**	**0**
	HCSIS	**0**	**MCI**	**4**
	MMIS	**3**	**Provider Web Portal**	**2**
	SAMS	**3**		



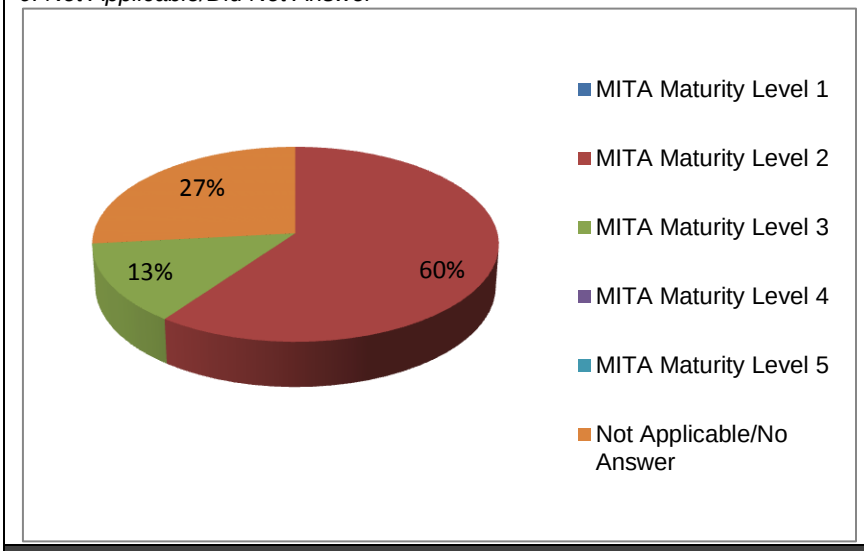
Assessment of Security and Privacy
The Security and Privacy technical service is rated at a level 2 or 3 in over half of the Pennsylvania Medicaid systems assessed. As Pennsylvania looks to improve maturity in this area, secure logon capabilities must include more robust biometric identify to further ensure the user accessing the systems matches the users original credentials. SSO capability will further ensure increased efficiency in this service.

4.4.6 Business Process Management

This table summarizes the results of the assessment of the TA used in Business Process Management.

Table 21: Business Process Management TA

MITA Technical Function and Description	PA Medicaid Systems			
Business Process Management				
The Business Process Management technical function focuses on the ability to support implementation of business process standards within this system. *Level 1: Primarily of manual paper-based activity to accomplish tasks. The SMA is not using MITA initiative for business, architecture and data.* *Level 2: Uses a mix of manual and automatic business processes. The SMA aligns business workflows with any provided by CMS in support of the Medicaid and Exchange business operation's and requirements* *Level 3: Specification and management of business processes in conformance with applicable standards (e.g., Business Process Execution Language (BPEL)).* *Level 4: Aligns to and advances increasingly in MITA maturity for business, architecture, and data. The SMA develops MMM Roadmap to monitor progress in MITA maturity. The SMA has full integration of the MITA initiative with business, architecture, and data within the interstate.* *Level 5: Asset supports targeted MITA maturity for business, architecture, and data. The SMA has full integration of the MITA initiative with business, architecture, and data within the nation.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**2**	**PAID**	**0**
	MPI	**2**	**CAPS**	**2**
	CaseNet	**2**	**CIS**	**0**
	Department Web Portal	**2**	**eCIS**	**3**
	ECM	**3**	**EDW**	**0**
	HCSIS	**2**	**MCI**	**2**
	MMIS	**2**	**Provider Web Portal**	**0**
	SAMS	**2**		



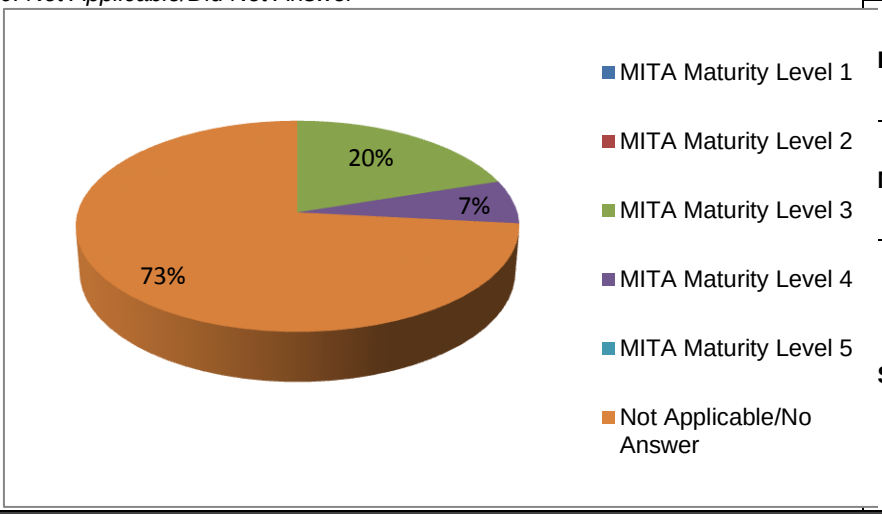
Assessment of Business Process Management
The Business Process Management technical function is rated as a MITA level 2 in 60% of the Medicaid systems currently used in Pennsylvania. This means a mix of manual and automated processes are used to support Commonwealth and federal program requirements. As Pennsylvania moves forward in maturity, a flexible process workflow should be included to promote standards and better identify training and system deficiencies.

4.4.7 Relationship Management

This table summarizes the results of the assessment of the TA used in Relationship Management.

Table 22: Relationship Management TA

MITA Technical Function and Description	PA Medicaid Systems			
Relationship Management				
The Relationship Management technical function focuses on the ability of the system to interface with external business entities for the purpose of data exchange. *Level 1: Manual (e.g., by attaching annotations to case files). Non-standardized definition and invocation of services.* *Level 2: Service support using architecture that does not comply with published MITA service interfaces and interface standards.* *Level 3: Basic Business Relationship Management (BRM), including tracking relationships between system users (e.g., members and providers) and the services requested and received. Services support using architecture that complies with MITA Framework, industry standards, and other nationally recognized interface standards.* *Level 4: Advanced BRM, this includes basic BRM plus analytics support and personalization capabilities. Services support using a cross-enterprise services registry.* *Level 5: Interstate BRM, which includes basic BRM plus analytics support and personalization capabilities. Services support using a cross-enterprise services registry.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**0**	**PAID**	**0**
	MPI	**0**	**CAPS**	**3**
	CaseNet	**0**	**CIS**	**0**
	Department Web Portal	**0**	**eCIS**	**0**
	ECM	**0**	**EDW**	**0**
	HCSIS	**0**	**MCI**	**3**
	MMIS	**3**	**Provider Web Portal**	**0**
	SAMS	**4**		



Assessment of Relationship Management

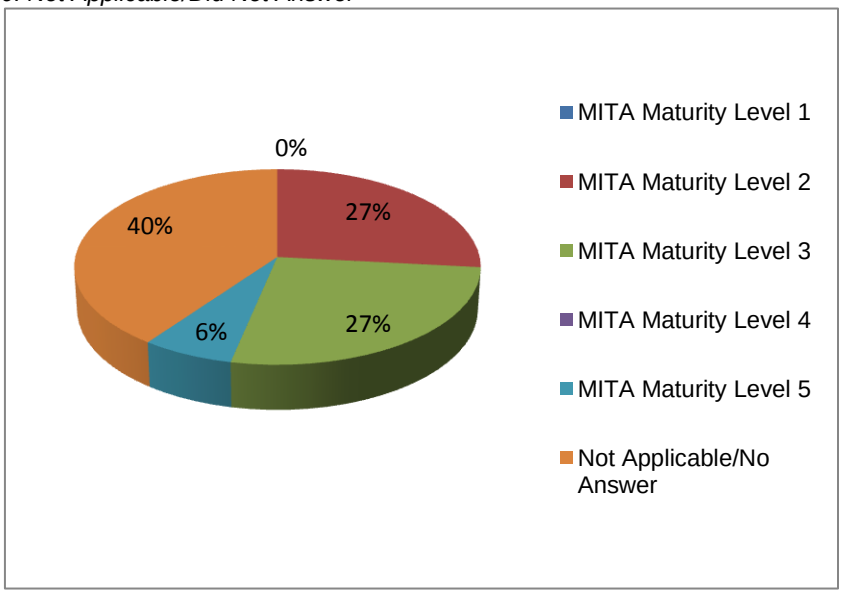
The Relationship Management technical function is believed to be not applicable in 73% of the Medicaid systems currently used in Pennsylvania. The remaining 27% believe to be at a level 3 or 4. As a result, the BRM that occurs within those systems has some measureable amount of relationship tracking and uses standards. As Pennsylvania improves capabilities in this area, the focus should be on increased standard metrics as well as promoting dashboard reporting of relationship improvements.

4.4.8 Data Connectivity

This table summarizes the results of the assessment of the TA used in Data Connectivity.

Table 23: Data Connectivity TA

MITA Technical Function and Description	PA Medicaid Systems			
Data Connectivity				
The Data Connectivity technical function focuses on the ability of this system to use an enterprise standard data exchange between other systems and entities. *Level 1: Manual data exchange between multiple organizations, sending data requests via telephone or e-mail to data processing organizations and receiving requested data in nonstandard formats and in various media (e.g., paper, facsimile, EDI).* *Level 2: ED exchange with multiple organizations via an information hub using secure data, in which the location and format are transparent to the user and the results delivered in a defined style that meets the user's needs.* *Level 3: ED exchange with multiple organizations via an information hub that can perform advanced information monitoring and route alerts/alarms to communities of interest if the system detects unusual conditions.* *Level 4: Use of comprehensive data models to communicate between different data formats. Adoption of enterprise integration strategy. Migration from a point-to-point to message based exchange. Data exchange across intrastate agencies and with some external entities.* *Level 5: Use of comprehensive data models to communicate between intrastate and interstate agencies, federal entities, and health care stakeholders.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**0**
	MPI	**0**	**CAPS**	**3**
	CaseNet	**2**	**CIS**	**3**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**0**	**EDW**	**2**
	HCSIS	**2**	**MCI**	**0**
	MMIS	**2**	**Provider Web Portal**	**0**
	SAMS	**5**		
Assessment of Data Connectivity				

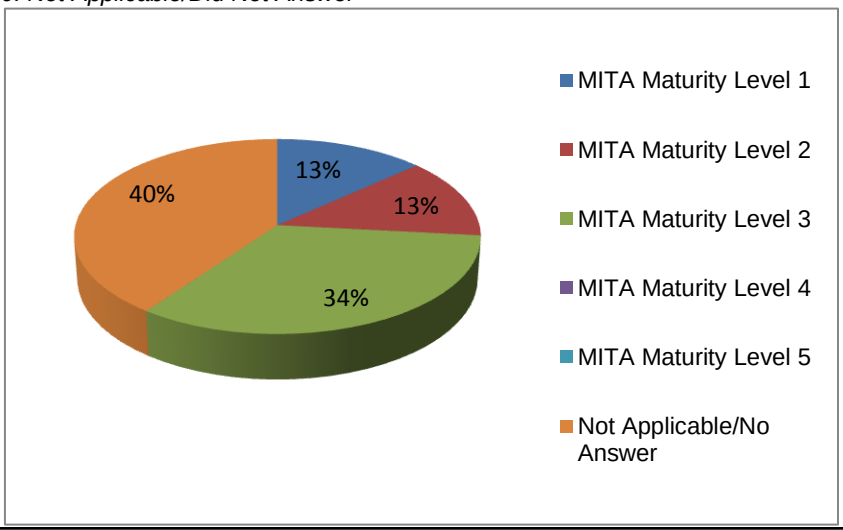


MITA Technical Function and Description	PA Medicaid Systems
The Data Connectivity technical function exists is rated at a MITA level 1, 2, or 3 in 60% of the Medicaid systems currently used in Pennsylvania. To increase MITA maturity, ED exchange should concentrate on information hubs and consistent use of data models. Forty percent of systems believe this technical function does not apply.	

4.4.9 Service Oriented Architecture

This table summarizes the results of the assessment of the TA used in SOA.

Table 24: SOA TA

MITA Technical Function and Description	PA Medicaid Systems			
SOA				
The SOA technical function focuses on the ability of the functionality structure within the system to be independent objects, each with standard inputs and outputs. These objects are loosely-coupled with no embedded external calls. SOA promotes reusability, granularity, and interoperability. *Level 1: Non-standardized approaches to orchestration and composition of functions within and across the Health care Enterprise.* *Level 2: Reliable messaging, including guaranteed message delivery (without duplicates) and support for non-deliverable messages.* *Level 3: MITA-compliant ESB, automated arrangement, coordination and management of system. System coordination between intrastate agencies and some external entities.* *Level 4: MITA-compliant ESB, use of SOA and SDLC for Health care Enterprise. Interoperable outside of HHS, interstate, and other health care stakeholders, such as, HIE or HIX.* *Level 5: MITA-compliant ESB, use of SOA and SDLC for Health care Enterprise. Interoperable extends to federal agencies.* *0: Not Applicable/Did Not Answer* 	**COMPASS**	**3**	**PAID**	**0**
	MPI	**2**	**CAPS**	**3**
	CaseNet	**1**	**CIS**	**0**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**0**	**EDW**	**1**
	HCSIS	**0**	**MCI**	**2**
	MMIS	**3**	**Provider Web Portal**	**0**
	SAMS	**3**		
Assessment of SOA				

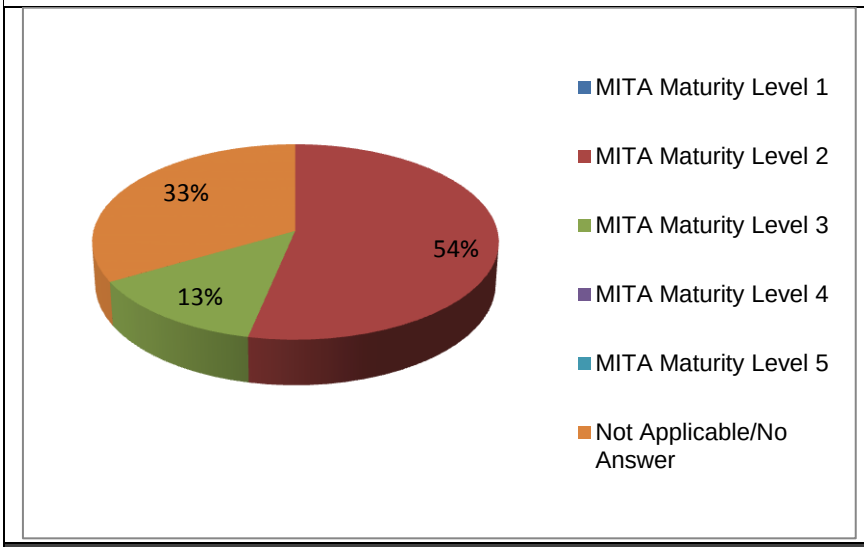
MITA Technical Function and Description	PA Medicaid Systems
The SOA technical function is believed to be primarily at level 3 or not applicable. Some of the systems listed as not applicable should be reconsidered as all services across the PME should be included in the SOA strategy and prioritized by Enterprise Governance. Like the ESB, SOAs is vital for improving MITA maturity to level 3 and beyond. SOA increases system efficiency by allowing services to be accessed over a network so users can combine or reuse them for their business applications. This loose coupling of services allows for applications within systems to be written independently and replaced when needed without having to rewrite code for the entire system.	

4.4.10 System Extensibility

This table summarizes the results of the assessment of the TA used in System Extensibility.

Table 25: System Extensibility TA

MITA Technical Function and Description	PA Medicaid Systems			
System Extensibility				
The System Extensibility technical function focuses on the ability of this system to extend functionality across the Enterprise. *Level 1: Does not use web services. The SMA conducts extensive code changes for additional system functionality.* *Level 2: Uses a mix of manual and electronic transactions to conduct business activity. The SMA uses some isolated web services.* *Level 3: Uses Representational State Transfer (RESTful) and/or Simple Object Access Protocol (SOAP)-based web services for seamless coordination and integration with other HHS applications and intrastate agencies including the HIX.* *Level 4: Supports RESTful and SOAP-based web services with interstate agencies including Health Information Organizations (HIOs) and the HIE. The SMA adopts web services of Nationwide Health Information Network (NwHIN) priority areas.* *Level 5: Supports RESTful and SOAP-based web services with all available federal agencies (i.e., IRS). The SMA increases federation and intrinsic interoperability Not Applicable with minimal impact for new service capability. The SMA adopts full usage of NwHIN with exposed services to all appropriate parties.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**0**
	MPI	**2**	**CAPS**	**2**
	CaseNet	**0**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**2**
	ECM	**2**	**EDW**	**0**
	HCSIS	**2**	**MCI**	**3**
	MMIS	**2**	**Provider Web Portal**	**0**

MITA Technical Function and Description	PA Medicaid Systems			
	**SAMS**	**2**		

Assessment of System Extensibility

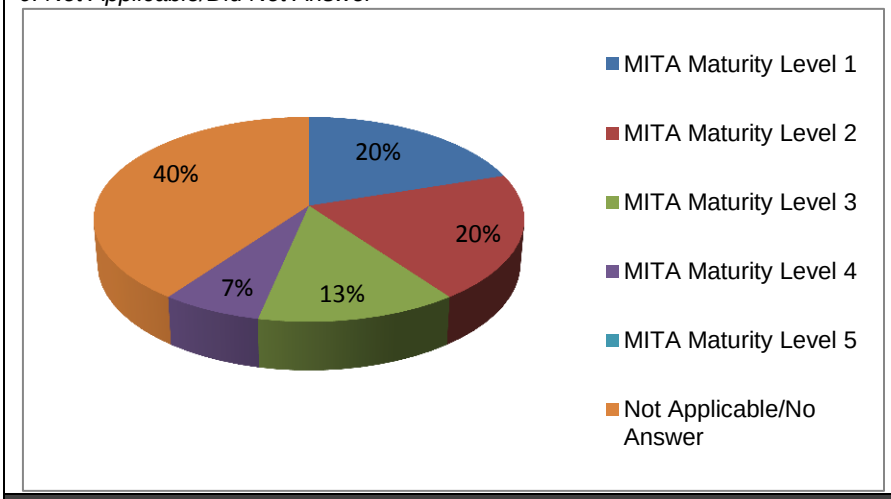
The Systems Extensibility technical function is rated as MITA level 2 in about 54% of the systems assessed in Pennsylvania. As this technical function increases in MITA maturity, emphasis should be put on coordinating and integrating with other Commonwealth and federal agencies to improve efficiency in sharing functionality.

4.4.11 Configuration Management

This table summarizes the results of the assessment of the TA used in Configuration Management.

Table 26: Configuration Management TA

MITA Technical Function and Description	PA Medicaid Systems			
Configuration Management				
The Configuration Management technical function focuses on the ability for end-users to configure business rules to meet changing business needs. *Level 1: Technology-dependent interfaces to applications that are significantly affected by the introduction of new technology.* *Level 2: Technology-neutral interfaces that localize and minimize the impact of the introduction of new technology (e.g., data abstraction in data management services to provide product-neutral access to data based on metadata definitions).* *Level 3: Use of Software Configuration Management to reproduce solutions in a controlled, incremental fashion, rather than focusing on controlling solution products. Identification of configuration items and baselines.* *Level 4: Utilization of Build Management, Process Management, and Environment Management through the SDLC. Development process between intrastate agencies and some external entities.* *Level 5: Full utilization of Build Management, Process Management, and Environment Management through the SDLC. Development process between intrastate and interstate agencies, federal entities and external health care stakeholders.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**0**	**PAID**	**0**
	MPI	**0**	**CAPS**	**4**
	CaseNet	**2**	**CIS**	**1**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**3**	**EDW**	**1**
	HCSIS	**2**	**MCI**	**0**
	MMIS	**1**	**Provider Web Portal**	**0**
	SAMS	**2**		



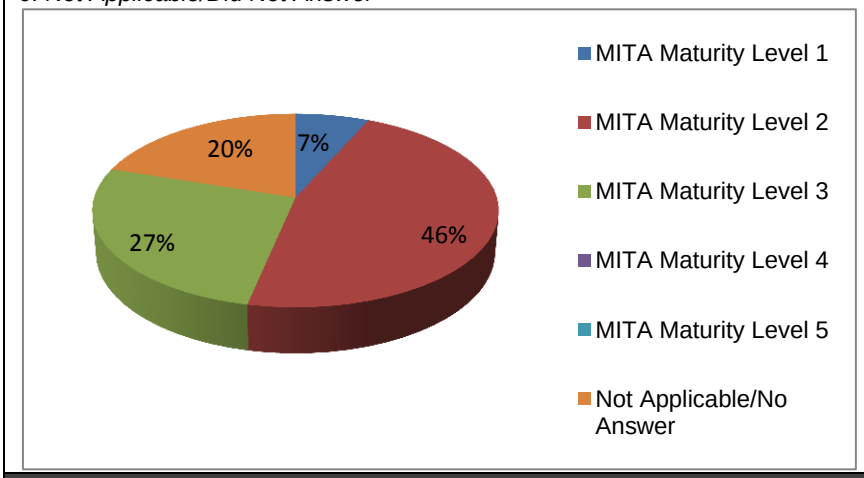
Assessment of Configuration Management
The Configuration Management technical function is rated at MML 1 or level 2 in about 40% of the Medicaid systems currently used in Pennsylvania, with another 40% saying it does not apply. The ability for end users to configure business rules to suit their needs will become increasingly important as Pennsylvania improves their MITA maturity. Business rules will become increasingly complex and unique for the various end users. Having the flexibility to quickly adapt will allow business processes to perform their functions efficiently and effectively.

4.4.12 Data Access Management

This table summarizes the results of the assessment of the TA used in Data Access Management.

Table 27: Data Access Management TA

MITA Technical Function and Description	PA Medicaid Systems			
Data Access and Management				
The Data Access and Management technical function focuses on the system's ability to receive, translate, and process all data necessary to support business needs. *Level 1: Ad hoc formats for data exchange. Ad hoc, point-to-point approaches to systems integration. No use of enterprise-wide data standards.* *Level 2: Data resides in one schema with tight coupling approach. Single source of data. Data model that conforms to the MITA Framework and maps data exchanged with external organizations to the model.* *Level 3: Data exchange (internally and externally) using MITA Framework, industry standards, and other nationally recognized standards. Service-enabling legacy systems using MITA Framework, industry standards, and other nationally recognized standards. Data resides in multiple locations; however, it is accessible to users providing uniform access in a mediated schema.* *Level 4: Data exchange (internally and externally) in conformance with MITA Framework, industry standards, and other nationally recognized semantic data standards (ontology-based).* *Level 5: Data model that conforms to shared data used by all business processes includes MITA Framework, industry standards, and other nationally recognized standards for clinical data and EHRs.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**0**
	MPI	**2**	**CAPS**	**2**
	CaseNet	**2**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**0**	**EDW**	**1**
	HCSIS	**2**	**MCI**	**2**
	MMIS	**3**	**Provider Web Portal**	**3**
	SAMS	**2**		



Assessment of Data Access and Management

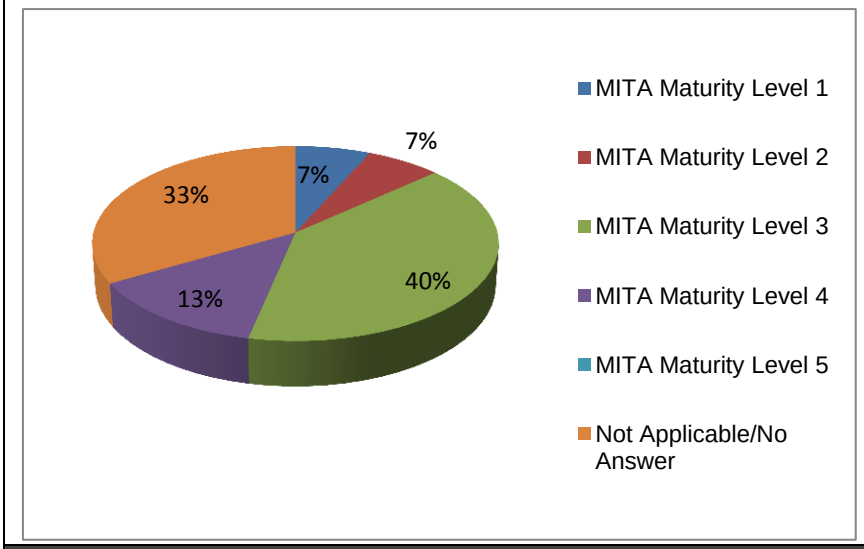
The Data Access and Management technical function is rated as a MITA level 1 or level 2 in 53% of the Medicaid systems currently used in Pennsylvania. This means that the data schemas are unique to most systems and data exchange is done in a tight coupling approach. The Commonwealth will need to begin to leverage data models and begin to standardize the processes used in data sharing across the enterprise. A focus on each extract, transform, and load (ETL) opportunity could be a strategy to prioritize the development of standards in data exchange.

4.4.13 Decision Management

This table summarizes the results of the assessment of the TA used in Decision Management.

Table 28: Decision Management TA

MITA Technical Function and Description	PA Medicaid Systems			
Decision Management				
The Decision Management technical function focuses on the ability to create and execute business rules within the system in both human and machine-readable format. *Level 1: Manual application of rules (and consequent inconsistent decision-making).* *Level 2: Business rules imbedded in the core application code and executed in a batch-operating environment.* *Level 3: Business rules reside in a separate application or Rules Engine. Rules executed in a runtime environment. Use of production/inference rules to represent behaviors (e.g., IF Then conditional logic).* *Level 4: Rules engine utilizes technical call-level interface using API standard. Use of Event Condition Action rules. The reactive rule engines detect and react to incoming events and process event patterns.* *Level 5: Deterministic rules engine that utilizes domain-specific language.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**0**	**PAID**	**0**
	MPI	**0**	**CAPS**	**4**
	CaseNet	**3**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**4**	**EDW**	**1**
	HCSIS	**3**	**MCI**	**0**
	MMIS	**3**	**Provider Web Portal**	**3**
	SAMS	**3**		



Assessment of Decision Management

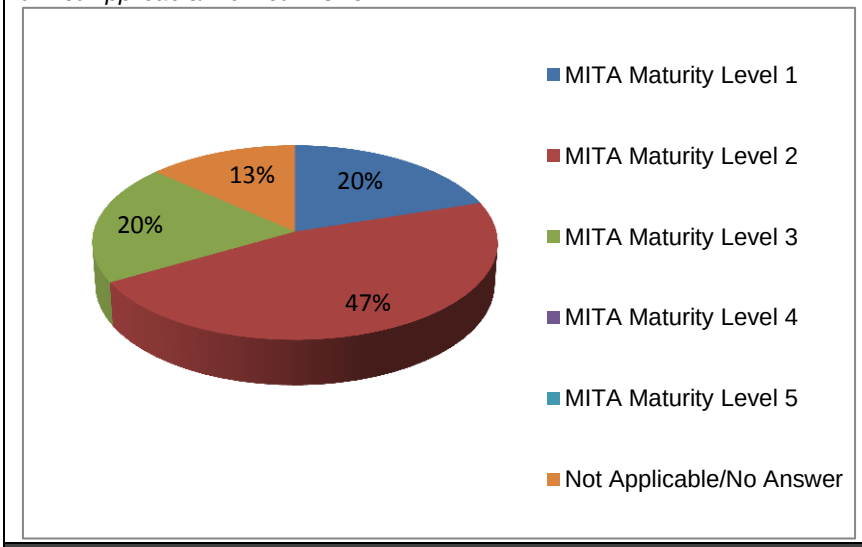
The Decision Management technical function is rated at a MITA level 1, 2, or 3 in 54% of systems, while 33% believe it does not apply. A key requirement of the 7C&S is the ability to separate the business rules from system coding. CMS is further requiring that states have the ability to share business rules with other states. Pennsylvania should focus on expanding the number of systems with the ability to separate business rules with the longer term strategy of consolidating like systems across the enterprise. ECM and CAPS believes to be at a level 4.

4.4.14 Logging

This table summarizes the results of the assessment of the TA used in Logging.

Table 29: Logging TA

MITA Technical Function and Description	PA Medicaid Systems			
Logging				
The Logging technical function focuses on the ability of this system to log, audit, and report access attempts. *Level 1: Access to system capabilities via logon identification and password. Manual logging and analysis.* *Level 2: Access to the history of a user's activities and other management functions, including logon approvals and disapprovals and log search and playback.* *Level 3: User authentication using public key infrastructure in conformance with MITA Framework, industry standards, and other nationally recognized standards. User access to system resources depending on their role at sign-on.* *Level 4: Use of contemporary enterprise based auditing tools such as TrustedBSD, or OpenBSM to generate and process audit records.* *Level 5: Use of open source components, such as, OpenXDAS.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**0**	**PAID**	**0**
	MPI	**3**	**CAPS**	**2**
	CaseNet	**3**	**CIS**	**1**
	Department Web Portal	**2**	**eCIS**	**2**
	ECM	**2**	**EDW**	**1**
	HCSIS	**2**	**MCI**	**2**
	MMIS	**3**	**Provider Web Portal**	**2**
	SAMS	**1**		



Assessment of Logging

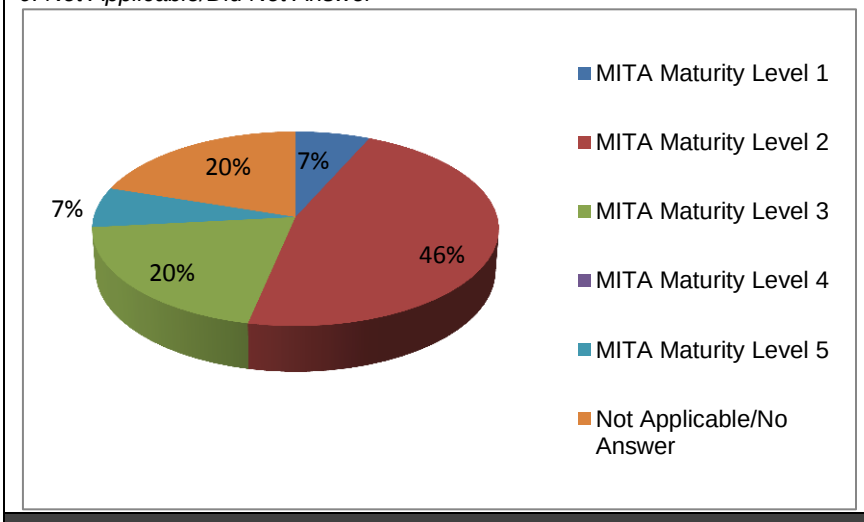
The Logging technical function is rated as MITA level 2 in 47% of the Medicaid systems currently used in Pennsylvania. Another 40% of systems are mostly a mix of levels 1 and 3. This functionality detects attempts to access a system and logs that information in a measure to increase security. Pennsylvania should focus on further promoting access through biometric identification in the case where protected health information (PHI) may be present.

4.4.15 Utility

This table summarizes the results of the assessment of the TA used in Utility.

Table 30: Utility TA

MITA Technical Function and Description	PA Medicaid Systems			
Utility				
The Utility technical function focuses on the ability of this system to meet the intended business needs of the Enterprise. *Level 1: Asset requires manual activity to accomplish unique tasks. The SMA conducts Research and Development experimentation where pilot project(s) are taking place using state-specific standards. Uses minimal web service utility type services in isolated areas.* *Level 2: Uses simple architected software services involving database integration and reliable messaging. Supports versioning, mediation, and distributed systems. Supports integration of multiple applications. Incorporates industry standards in requirements, development, and testing phases of projects including security measures. The SMA conducts initial performance management activities.* *Level 3: Uses a set of computer programs to perform unique business and technical tasks. Uses business processes orchestration in an event-driven environment. Does have transactions that take long time to execute. Uses composite applications including initial external service enablement. Uses SDLC governance activities. Adopts all industry standards set by the HHS Secretary for requirements, development, and testing phases of projects.* *Level 4: Uses measured business services involving business activity monitoring along with event-driven dashboard information. Supports multiple enterprises involving shared Business-to-Business services.* *Level 5: Provides services to the stakeholder community to perform business functions without human intervention. Supports self-correcting business processes. Supports real-time event stream processing to optimize service offering.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**0**
	MPI	**0**	**CAPS**	**3**
	CaseNet	**2**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**2**	**EDW**	**1**
	HCSIS	**2**	**MCI**	**2**
	MMIS	**2**	**Provider Web Portal**	**5**
	SAMS	**2**		
Assessment of Utility				



MITA Technical Function and Description	PA Medicaid Systems
The Utility technical function is rated as a MITA level 1 or level 2 in about 53% of the Medicaid systems currently used in Pennsylvania. The remaining is mostly rated at a level 3 or believes it is not applicable. One current challenge facing most states is focusing on procuring COTS products that also meet the unique needs of Medicaid users. This can be balanced though the systems integration process.	

4.5 Pennsylvania Information Assessment Results by Technical Area

This section summarizes the results of the assessment of the As Is IA. The MITA IA is focused on the information and data management capabilities of the Medicaid Enterprise. The primary area of focus for this architecture includes the data management strategy as well as data modeling.

The results for each information capability are presented in a table format. Each table contains a brief description of the MITA information capability, a description of the As Is circumstances of that information capability based on results from the 15 primary systems surveyed, and a pie chart showing a graphical representation of the survey results. The maturity assessment for the information capability relative to each system is also included.

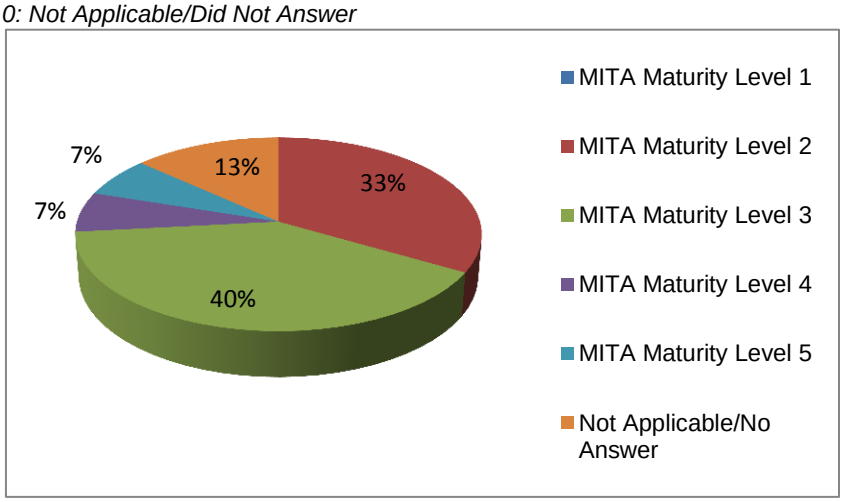
The survey results are meant to provide a basic idea of current system capabilities related to MITA functionality. However, the survey responses are provided by systems staff and may not reflect desired IA improvements outlined by the business capability assessment and MITA To Be Roadmap.

For the complete set of technical survey results, see Appendix E: Technical Survey Results. The technical survey included questions related to the IA.

4.5.1 Data Management Strategy

This table summarizes the results of the assessment of the IA for the Data Management Strategy.

Table 31: Data Management Strategy IA

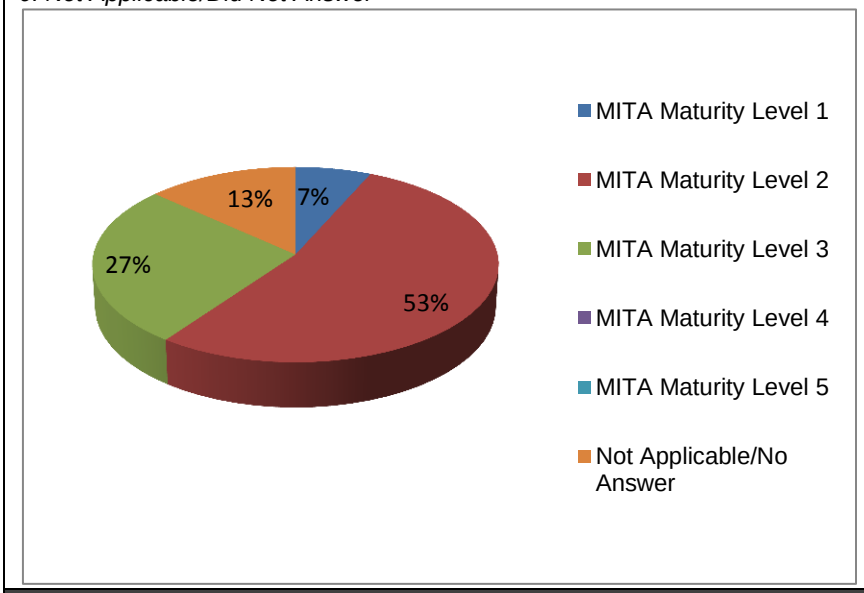
MITA Information Capability and Description	PA Medicaid Systems			
Data Management Strategy: Data Governance				
The Data Management Strategy component provides a structure that facilitates the development of information/data, effectively shared across a state Medicaid Enterprise to improve mission performance. *Level 1: No data governance implemented.* *Level 2: Implementation of internal policy and procedures to promote data governance, data stewards, data owners, and data policy.* *Level 3: Adoption of governance process and structure to promote trusted data governance, data stewards, data owners, data policy, and controls redundancy within intrastate.* *Level 4: Participation in governance, stewardship, and management process with regional agencies to promote sharing of Medicaid resources.* *Level 5: Participation in governance, stewardship, and management process with CMS and other national agencies and groups to promote sharing of Medicaid resources.* *0: Not Applicable/Did Not Answer*  	**COMPASS**	**3**	**PAID**	**0**
	MPI	**2**	**CAPS**	**3**
	CaseNet	**2**	**CIS**	**3**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**3**	**EDW**	**2**
	HCSIS	**2**	**MCI**	**3**
	MMIS	**4**	**Provider Web Portal**	**2**
	SAMS	**5**		
Assessment of Data Management Strategy				
The Data Management Strategy information function is rated as a MITA level 2 or 3 in 73% of the Medicaid systems currently used in Pennsylvania. This means that the data schemas are unique to most systems and governance processes are adopted. Twenty percent of systems are either at level 1 or believed to be not applicable. These systems will have to implement some sort of internal policy or other procedures to promote data governance.				

4.5.2 Enterprise Data Architecture

This table summarizes the results of the assessment of the IA for the Enterprise Data Architecture.

Table 32: Enterprise Data Architecture IA

MITA Information Capability and Description	PA Medicaid Systems			
Data Management Strategy: Enterprise Data Architecture				
The Data Management Strategy component provides a structure that facilitates the development of information/data, effectively shared across a state Medicaid Enterprise to improve mission performance. *Level 1: No standards for data architecture development.* *Level 2: Implementation of internal policy and procedures to promote data documentation, development, and management where the SMA defines data entities, attributes, data models, and relationships sufficiently to convey the overall meaning and use of Medicaid data and information.* *Level 3: Adoption of intrastate metadata repository where the SMA defines the data entities, attributes, data models, and relationships sufficiently to convey the overall meaning and use of Medicaid data and information.* *Level 4: Adoption of a regional metadata repository where the SMA defines the data entities, attributes, data models, and relationships sufficiently to convey the overall meaning and use of Medicaid data and information.* *Level 5: Adoption of a national centralized metadata repository where the SMA defines the data entities, attributes, data models, and relationships sufficiently to convey the overall meaning and use of Medicaid data and information.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**0**
	MPI	**2**	**CAPS**	**3**
	CaseNet	**1**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**2**
	ECM	**2**	**EDW**	**2**
	HCSIS	**2**	**MCI**	**2**
	MMIS	**3**	**Provider Web Portal**	**2**
	SAMS	**3**		



Assessment of Enterprise Data Architecture

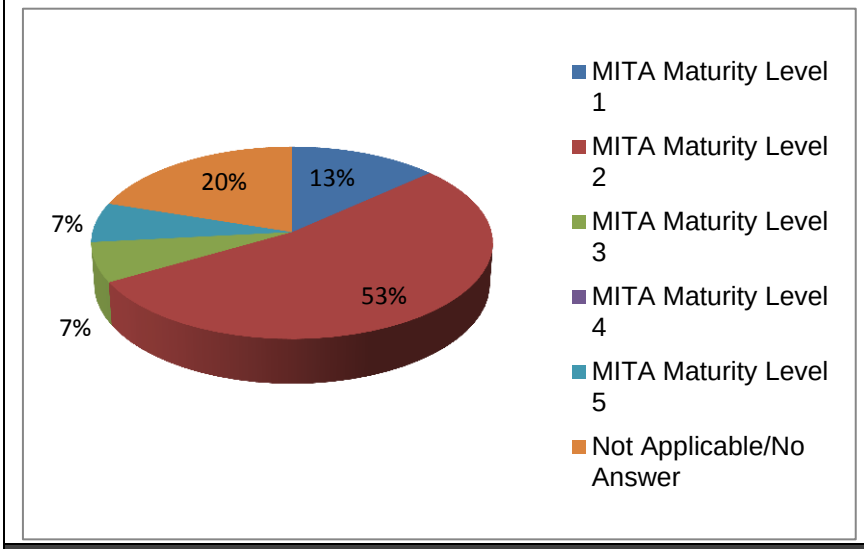
The Enterprise Data Architecture information function is rated as a MITA level 2 in 53% of the Medicaid systems currently used in Pennsylvania. This means that the data architectures are unique to most systems and data exchange is done in ad hoc, point to point fashion. To increase the number of systems to level 3, adoption of intrastate data repositories will become a key focus.

4.5.3 Enterprise Modeling

This table summarizes the results of the assessment of the IA for the Enterprise Modeling Strategy.

Table 33: Enterprise Management Strategy IA

MITA Information Capability and Description	PA Medicaid Systems			
Data Management Strategy: Enterprise Modeling				
The Data Management Strategy component provides a structure that facilitates the development of information/data, effectively shared across a state Medicaid Enterprise to improve mission performance. *Level 1: No enterprise modeling exists.* *Level 2: Implementation of Medicaid internal policy and procedures to promote enterprise modeling.* *Level 3: Adoption of intrastate enterprise modeling to promote standardized data across data source systems and third-party resources to decrease resource expenditure and increase enterprise knowledge.* *Level 4: Adoption of regional enterprise modeling to promote standardized data across data source systems and third-party resources to decrease resource expenditure and increase enterprise knowledge.* *Level 5: Adoption of national enterprise modeling to promote standardized data across data source systems and third-party resources to decrease resource expenditure and increase enterprise.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**0**
	MPI	**2**	**CAPS**	**2**
	CaseNet	**2**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**2**
	ECM	**1**	**EDW**	**1**
	HCSIS	**2**	**MCI**	**0**
	MMIS	**2**	**Provider Web Portal**	**2**
	SAMS	**5**		



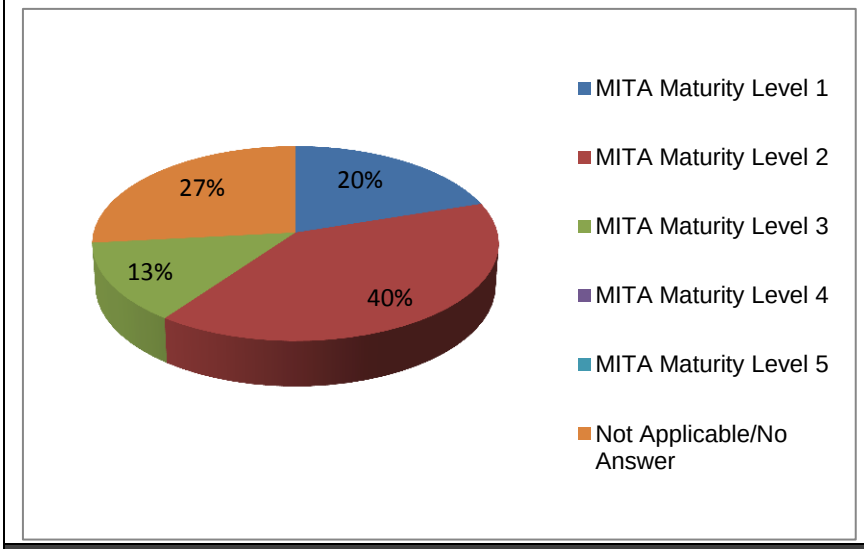
Assessment of Enterprise Modeling
The Enterprise Modeling information function is at a level 2 in 53% of the Medicaid systems currently used in Pennsylvania. As a result, data models are largely focused on internal policy for enterprise modeling. In order to increase in MITA maturity, emphasis will need to be placed on intrastate data modeling across the enterprise.

4.5.4 Data Sharing Architecture

This table summarizes the results of the assessment of the IA for the Data Management Strategy.

Table 34: Data Management Strategy IA

MITA Information Capability and Description	PA Medicaid Systems			
Data Management Strategy: Data Sharing Architectures				
The Data Management Strategy component provides a structure that facilitates the development of information/data, effectively shared across a state Medicaid Enterprise to improve mission performance. *Level 1: No sharing of data.* *Level 2: Development of Medicaid centralized data- and information-exchange formats.* *Level 3: Adoption of statewide standard data definitions, data semantics, and harmonization strategies.* *Level 4: Adoption of regional mechanisms used for data sharing (i.e., data hubs, repositories, and registries).* *Level 5: Adoption of national mechanisms used for data sharing (i.e., data hubs, repositories, and registries).* *0: Not Applicable/Did Not Answer*	**COMPASS**	**2**	**PAID**	**0**
	MPI	**0**	**CAPS**	**3**
	CaseNet	**1**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**2**
	ECM	**0**	**EDW**	**2**
	HCSIS	**2**	**MCI**	**1**
	MMIS	**2**	**Provider Web Portal**	**1**
	SAMS	**3**		



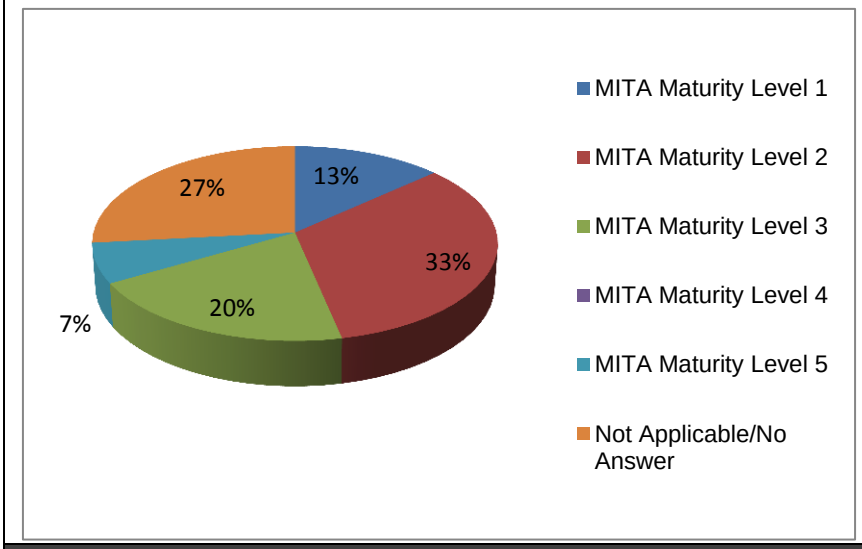
Assessment of Data Sharing Architectures
The Enterprise Data Sharing Architectures information function is rated as a MITA level 1 or 2 in 60% of the Medicaid systems currently used in Pennsylvania. This means that the data sharing architectures are unique to most systems interfaces and data exchange is done in ad hoc, point to point fashion. In order to increase in MITA Maturity, adoption of statewide, standard data definitions will be required.

4.5.5 Conceptual Data Model

This table summarizes the results of the assessment of the IA for the CDM component.

Table 35: CDM IA

MITA Information Capability and Description	PA Medicaid Systems			
CDM				
The CDM component represents the overall conceptual structure of the data, providing a visual representation of the data needed to run an enterprise or business activity. *Level 1: No CDM developed.* *Level 2: Adoption of diagrams or spreadsheets that depict the high-level data and general relationships within the agency.* *Level 3: Adoption of a CDM that depicts the high-level data and general relationships for intrastate exchange.* *Level 4: Adoption of a CDM that depicts the high-level data and general relationships with regional exchange including clinical information.* *Level 5: Adoption of a CDM that depicts the high-level data and general relationships with national exchanges.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**0**
	MPI	**2**	**CAPS**	**3**
	CaseNet	**2**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**3**
	ECM	**0**	**EDW**	**0**
	HCSIS	**2**	**MCI**	**2**
	MMIS	**1**	**Provider Web Portal**	**1**
	SAMS	**5**		



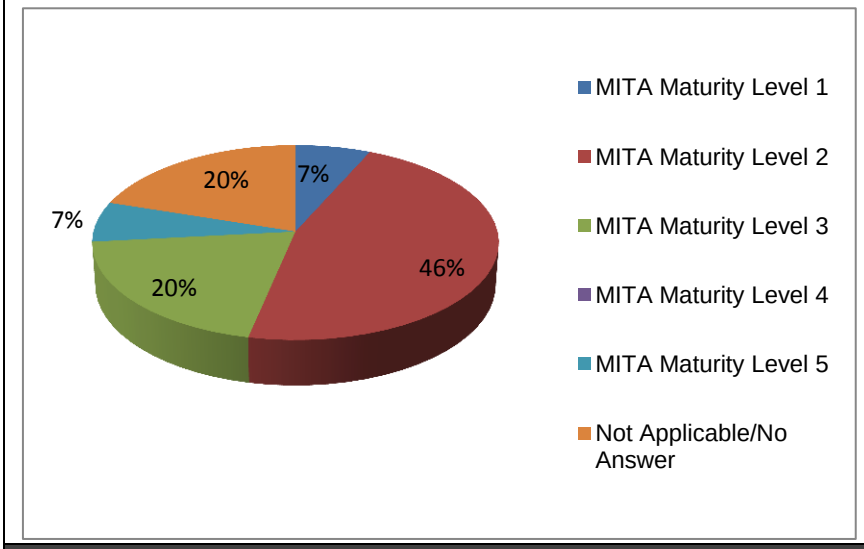
Assessment of CDM
The CDM information function is rated as a MITA level 1 or level 2 or not applicable in 73% of the Medicaid systems currently used in Pennsylvania. This means that the CDM for most systems is either non-existent or is documented in a non-standard format. To increase in MITA maturity, a standardized CDM should be developed that can be used across the Medicaid enterprise.

4.5.6 Logical Data Model

This table summarizes the results of the assessment of the IA for the LDM component.

Table 36: LDM IA

MITA Information Capability and Description	PA Medicaid Systems			
LDM				
The LDM component Identifies all of the logical data elements that are in motion in the system or shared within the state Medicaid Enterprise. *Level 1: No LDM developed.* *Level 2: Identification of data classes and attributes relationships, data standards, and code sets within the agency.* *Level 3: LDM identifies the data classes, attributes, relationships, standards, and code sets for intrastate exchange.* *Level 4: LDM identifies data classes, attributes, relationships, standards, and code sets for regional exchange including clinical information.* *Level 5: LDM identifies data classes, attributes, relationships, standards, and code sets for national exchange.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**3**	**PAID**	**0**
	MPI	**2**	**CAPS**	**3**
	CaseNet	**2**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**2**
	ECM	**0**	**EDW**	**2**
	HCSIS	**2**	**MCI**	**2**
	MMIS	**3**	**Provider Web Portal**	**1**
	SAMS	**5**		



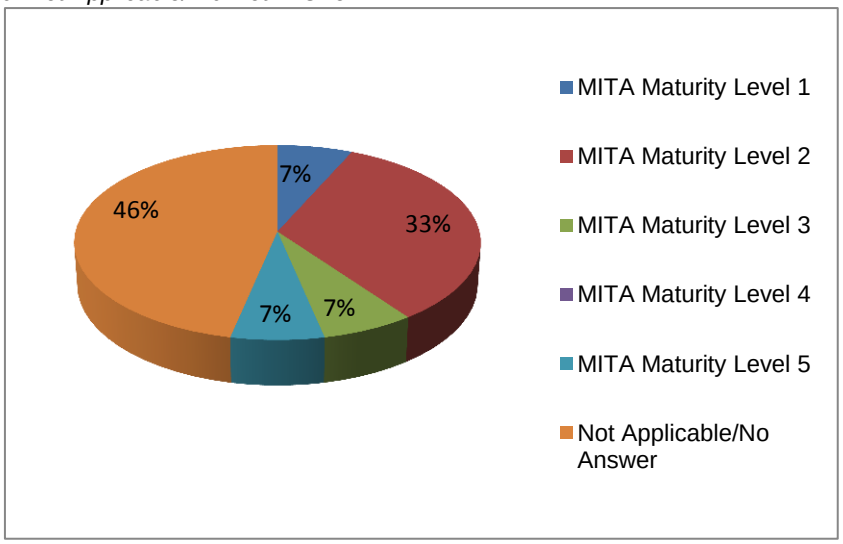
Assessment of LDM
The LDM information function is rated as a MITA level 1 or level 2 in 73% of the Medicaid systems currently used in Pennsylvania. This means that the LDM for most systems is either non-existent or is documented in a non-standard format. To increase in MITA maturity, a standardized LDM should be developed that can be used across the Medicaid enterprise.

4.5.7 Data Standards

This table summarizes the results of the assessment of the IA for the Data Standards component.

Table 37: Data Standards IA

MITA Information Capability and Description	PA Medicaid Systems			
Data Standards				
The Data Standards component discusses the available data standards, the benefits of data standards, and using them. *Level 1: Asset uses non-standard structure and vocabulary data standards.* *Level 2: SMA implements internal structure and vocabulary data standards used for performance monitoring, management reporting, and analysis. SMA implements state-specific and HIPAA data standards.* *Level 3: Asset standardizes structure and vocabulary data for automated electronic intrastate interchanges and interoperability. SMA implements MITA Framework, industry standards, and other nationally recognized standards for intrastate exchange of information.* *Level 4: Asset standardizes data for automated electronic regional interchanges and interoperability. SMA implements the MITA Framework, industry standards, and other nationally recognized standards for clinical and interstate exchange of information.* *Level 5: Asset standardizes data for automated electronic national interchanges and interoperability. SMA implements the MITA Framework, industry standards, and other nationally recognized standards for national exchange of information.* *0: Not Applicable/Did Not Answer*	**COMPASS**	**2**	**PAID**	**0**
	MPI	**2**	**CAPS**	**3**
	CaseNet	**2**	**CIS**	**2**
	Department Web Portal	**0**	**eCIS**	**0**
	ECM	**0**	**EDW**	**1**
	HCSIS	**0**	**MCI**	**0**
	MMIS	**2**	**Provider Web Portal**	**0**
	SAMS	**5**		



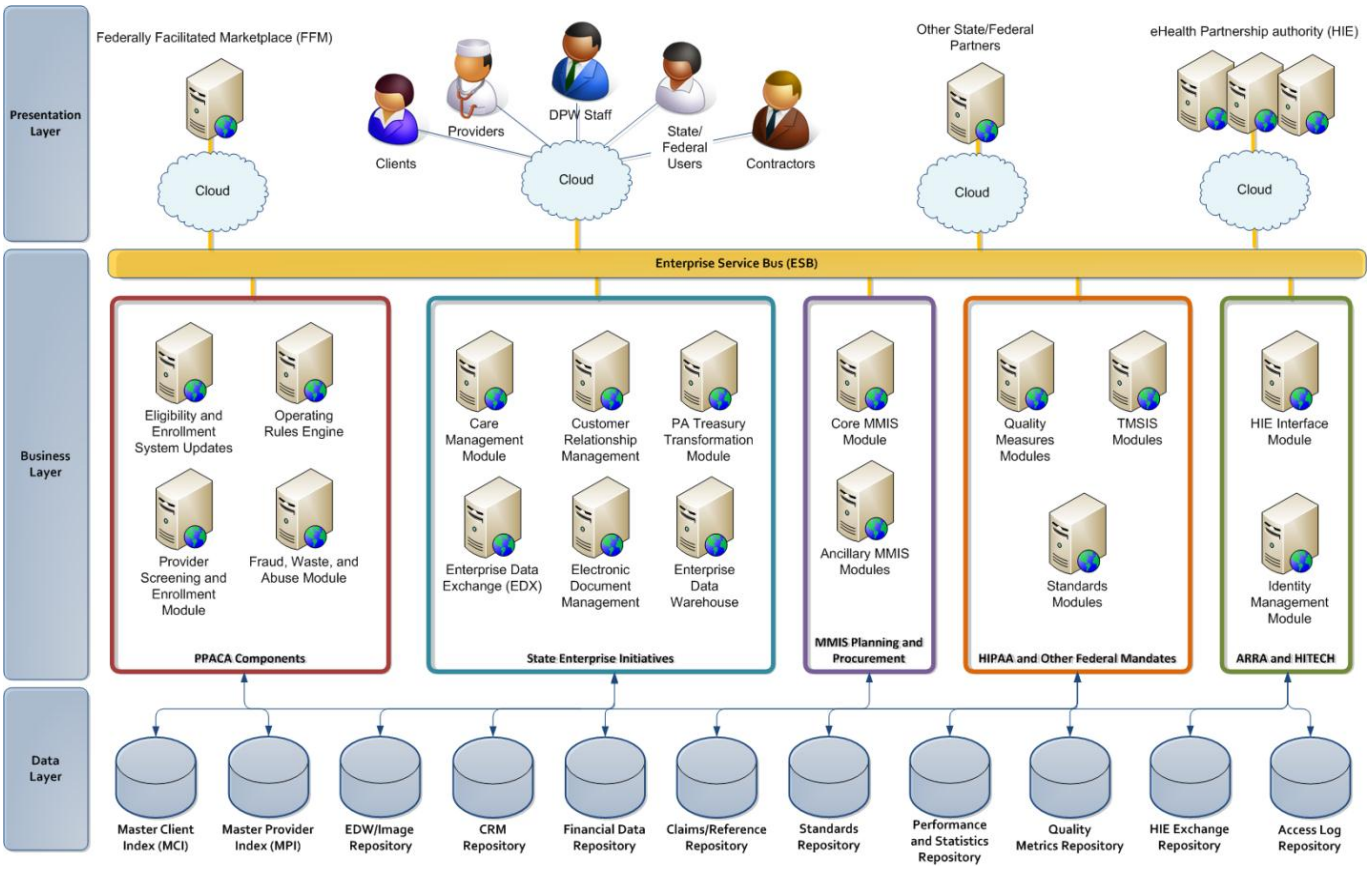
Assessment of Data Standards
The Data Standards information function is rated as a MITA level 1 or 2 in 40% of the Medicaid systems, while 46% believes it is not applicable. As a result, data standards are only implemented in a system by system basis and really do not act as an enterprise standard. In order to increase MITA maturity, data standards must be implemented for automated electronic interchanges and interoperability.

4.6 To Be Architecture and Technical Recommendations

On April 14, 2011, under Sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act, CMS issued new conditions and standards that must be met by the states in order for new technology investments (including claims processing and eligibility systems) to be eligible for enhanced matched funding.[12] CMS's intended purpose for implementing these conditions and standards for approving federal funding is to focus attention on the key elements of success for modern system development and deployment.

A modular approach to systems development is required by CMS in order to request enhanced funding for future systems updates. As a result, the diagram below provides a conceptual model of the Enterprise systems necessary to support the Commonwealth in the future. The diagram provides a recommendation for the future, but can be refined as strategy changes are identified.

Figure 17: To Be Conceptual TA



The technical recommendations included in this assessment align with the diagram above and are structured around the 7C&S to provide MITA 3.0 Roadmap support for each project on the Pennsylvania maturity timeline. For each of the 7C&S, this section provides a description of the condition or standard, the PME plan for meeting these requirements, and Cognosante recommendations relative to the condition or standard based on the MITA SS-A analysis.

[12] Centers for Medicare and Medicaid Services. Enhanced Funding Requirements: Seven Conditions and Standards. Medicaid IT Supplement (MITS-11-01-v1.0), April 2011, p. 1

The 7C&Sinclude:

- Modularity standard
- Industry standards condition
- MITA condition
- Leverage condition
- Business results condition
- Reporting condition
- Interoperability condition

4.6.1 Modularity Standard

The modularity standard requires the use of a modular, flexible approach to systems development, including the use of open interfaces and exposed API; the separation of business rules from core programming; and the availability of business rules in both human and machine-readable formats.

BA:

- *Implement a modular MMIS:* The To Be maturity goals identified for all business processes supported by the MMIS will require a more flexible MMIS, capable of responding quickly to the changing needs of the enterprise and able to support less static implementation of business rules.
- *Implement SOA:* SOA is a fundamental component in reaching for a MML goal of Level 3 over the next five (5) years. A key concept of SOA is the ability to replace system components, or modules, when business needs require new capabilities.
- *Implement rules engine capabilities:* The business assessment identified the need for rules engine capabilities. Using this tool, users can record business rules for many business functions as an essential component to a more flexible enterprise. Ideally, this rules engine will provide the flexibility and capability for Commonwealth staff to perform online changes (such as modifying rules, adding or changing benefit/reimbursement rate components, and adding a new provider type/service category) using a user-configuration feature to support desktop functionality without programming intervention.

IA:

- *Implement enterprise-wide standardization of data:* Standardizing data will ensure that shared information will be consistent among all system services and modules. This flexibility allows for system services to be swapped out or reused among other systems without having to worry about data compatibility between the services.

TA:

- *Implementing SOA:* A key concept of SOA is the ability to replace system components, or modules when businesses require new services.
- *Implement rules engine capabilities:* The technical assessment identified the need for rules engine capabilities. The rules engine allows policy changes to be entered into the PME systems more quickly and without programmer intervention in most cases.

4.6.2 MITA Condition

The MITA condition requires states to align to and increasingly advance in MITA maturity for business, architecture, and data. CMS expects the states to complete and continue to make measurable progress in implementing their MITA Roadmap.

BA:

- *Implement all HIPAA and MITA standard transactions and interfaces*: As they become available. This is a key element to achieving To Be goals. Use of MITA standards, as developed and released by CMS, is a requirement at MML 3 and beyond. Ensure the governance council is cognizant of MITA standards and confirm alignment as standards change. Under direction of the governance council, plan annual MITA SS-A activities and requirements.

IA:

- *Implement a data governance team:* With the impacts of HITECH, ICD-10, ACA, and MITA maturity improvements, a comprehensive plan to address ongoing system and data governance would benefit the PME. This governance would follow the agreed recommendations and plans made through future MITA transition planning activities. The governance team should be comprised of key stakeholders and senior management staff. The group should meet monthly to facilitate change management and review action items, issues, and risks associated with achieving the goals and objectives of the full project life cycle.
- *Manage data quality, data risks, and impacts:* Data governance and project planning under full configuration management also involves managing data quality, data risks, and the overall impact of data on business processes. Responsibility for this governance should be a subset of the system governance team.

TA:

- *Implement a system governance team:* With the impacts of HITECH, ICD-10, ACA, and MITA maturity improvements, a comprehensive plan to address ongoing system governance would be beneficial. Business process analysis and re-engineering is a key driver of SOA, which should be adopted over time with targeted projects as a part of system governance. This is a key concept because consideration should be made to modularize current functionality. The modularization will reduce the risk of large systems implementations.
- The general governance council structure includes at least the decision areas of: a) business and technology alignment, b) architecture and security, and, c) operations. Each governance council shall have representation from all member agencies at an appropriate organizational level to conduct the council's business.

4.6.3 Industry Standards Condition

The Industry Standards Condition requires States to ensure alignment with, and incorporation of industry standards. This covers 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 ACA; and standards and protocols adopted by the Secretary under Section 1561 of the ACA.

The PME is challenged with coordinating program changes across all agencies. However, a key element creating challenges for the enterprise is the lack of enterprise-wide standards in key areas. This factor was noted and most of the following themes emerged during both the business and technical assessments. To

support the To Be goals identified by SMEs, implementation of standards in the following areas is imperative:

BA:

- *Implement policy and program standards:* Supplementing the core point of formally documenting all policy and program requirements were key elements to include when establishing standards such as a consistent format, outlining which type of policy is appropriate to a given situation, and articulating the enterprise units that need to be notified of changes to a policy or requirement.
- *Improve training for all enterprise staff:* This includes associated training materials as needed to improve consistency in enterprise-wide understanding of policy, program requirements (such as federal and Commonwealth regulations that impact the Medicaid program), enterprise resources (people, data, and systems), and connections between Medicaid processes.
- *Expand the integration/centralization of similar processes:* A prime example of where this could benefit the enterprise is the rate setting process across MCOs, including behavioral health and CHIP. This capability will become increasingly critical as Pennsylvania expands its managed care population.
- *Manage business processes:* There is no documentation available at present that draws an enterprise-wide picture of the technical environment supporting business processes. It is imperative with MITA alignment that the Commonwealth stays apprised of leading-edge technology in order to leverage those system architectures and Web technologies that provide economical and flexible ways to manage the business processes. In order to ensure the efficient operation and management of various processes, the Commonwealth should consider upgrading (using change management methodology) its IT equipment on a periodic basis to keep automated technologies current. This last observation echoes statements repeatedly made by SMEs during sessions assessing the business processes regarding the need for updated desktop and server hardware and software to support process steps.[13]

IA:

- *Implement enterprise-wide standardization of data:* This standardization should occur across all programs and between all contractors and the enterprise (e.g., require all contractors to process information at the same level of detail). To facilitate the meeting of this goal, MITA standards and interfaces should be implemented as they are developed and released by CMS, and other industry standards beyond health care information (e.g., licensing information, financial information, etc.).
- *Establish a standard data model:* This is the most critical task associated with data governance and a key to the management of data. Establishing a defined data model will benefit the Commonwealth in several ways:
  - The Commonwealth will be better positioned to take advantage of emerging modular systems, reducing cost through increased competition. As part of the procurement process, the use of data exchanges using a standard data set should be a mandatory system requirement. Over time, this requirement will make it much easier to make decisions based on better functionality rather than having to interface between systems.
  - System improvements using a single model for data sharing and use provide system stability. This reduces the time and risks associated with systems implementations. Testing of interfaces and testing of modules can occur more quickly and with data predictable results.
  - Adopting an enterprise data model will better position the Commonwealth to systematically adopt national models and data standards adopted by the MITA Framework at Levels 4 and above in the future. The current EDW system includes some approach to managing data standards. However,

[13] For Medicaid funded positions, equipment can be upgraded periodically with federal funding by articulating the need in the APD.

the Commonwealth must move to a standard regional data model at Level 4 and 5. Furthermore, Pennsylvania has an opportunity to assist in the development of the national MITA data model, required at maturity Level 5, reducing its own long-term impacts. It is recommended that MITA Roadmap projects include the development of a standard data model that includes comprehensive transactional and analytical data for Pennsylvania Medicaid. Recipients and providers will benefit from improved interactions with the PME as predictable data values promote consistency and accuracy of information. A standard data model also makes it much easier to share and maintain accurate data across business units, reducing the risk of inconsistencies.

- *Adopt a federated data concept:* A federated data model requires any individual systems that maintain similar data to align with data standards. These systems are also required to utilize data staging for ETL activities.

TA:

- *Implement an enterprise governance structure:* This implementation will support setting and managing standards and process change of all types. This structure is essential to realizing the many improvements articulated by SMEs. In addition to the following three (3) technical themes, there were a number of items identified that would be part of a governance structure, as follows:
  - Data owners, rather than system security staff, would set rules for privacy of data relative to data sharing in conjunction with law and patient rights
  - Define requirements for periodic review of all types of standards (data, policy, procedure) for applicability, effectiveness, and currency with industry best practices
- Project management capabilities would be upgraded and improved
- Establishing a data governance as described in IA will allow the following
  - Ability to take advantage of emerging modular systems while reducing cost through increased competition. During procurements, the use of standardized data will be required for developing new systems.
  - System improvements using a single model for data sharing and use provide system stability. This will reduce the time and risks associated with systems implementations. Testing of interfaces and testing of modules can occur more quickly and with data predictable results.
- A federated data model requires any individual systems that maintain similar data to align with data standards. These systems are also required to utilize data staging for ETL.

4.6.4 Leverage Condition

The Leverage Condition requires State solutions to promote sharing, leveraging, and reuse of Medicaid technologies and systems within and among states. States can benefit substantially from the experience and investments of other states through the reuse of components and technologies already developed, consistent with a SOA, from publicly available or commercially sold components and products and from the use of cloud technologies to share infrastructure and applications.

BA:

- *Adopt an enterprise strategy around the concept of cloud computing:* Cloud computing promotes the practice of distributing software applications over high-speed Internet connections from remote data centers so that members, providers, staff, and other users can use them on any device with online access. Pennsylvania would benefit from adopting centralized or federated data concepts for hardware storage and other services that help navigate the increasing amount of information flowing in from stakeholder interactions with the PME.

IA:

- *Automate access to clinical data:* This is a key element in achieving MML 4. While most processes across the PME are targeting MML 2, both the Commonwealth and its CMS partner have identified the importance of accessing clinical data. For this reason, CMS is funding the clinical data access component of MML 4, knowing that states may be several years away from achieving the remaining MML 4 capabilities.
- *Implement a comprehensive robust data model:* The current Title XIX databases across the enterprise do not meet the reporting and data analysis needs of the Commonwealth. Among the capabilities desired for the data warehouse is organization of the data so that it facilitates a variety of data analysis and decision support activities, which allow users to drill down into deeper levels of detail. This includes the automated balancing of updates to ensure accuracy, and the capability to interface with COTS analysis products.
- *Make use of metadata repositories:* These repositories are a collection of stored original/real data tables (views) that can be reused and modified to further integrate systems and information. Complete, well-defined, and accessible metadata enables the business analysts to access and understand the data with minimum reliance on IT support. A data dictionary is also part of the metadata repository maintained in the data warehouse. The dictionary contains listings of data warehouse tables and data elements, source-to-target mappings, and data transformation rules for creating data categories, summaries, and cataloging archived information. Metadata naming standards can be applied to schemas, databases, table spaces, tables, rows, columns, and indexes in the data warehouse to specifically address reporting and analytic requirements. When metadata definitions are complete, accurate, and written in narrative form, it helps the user to easily understand despite a lack of technical knowledge. The domain values help users to understand the applicable valid values for each data element. The implementation of metadata repositories would benefit the enterprise as metadata is:
  - Easily accessible by the data warehouse end user
  - Structured so it is easily navigated by the non-technical data warehouse user
  - Updated in a timely manner and maintained through the duration of the contract
  - Easily understood by the non-technical data warehouse user

TA:

- *Centralize real-time availability of information:* Centralizing information is needed by multiple enterprise units/functions (e.g., scanned documents, analysis work products, policy documents etc.). The ability to index information to facilitate access was emphasized repeatedly. SMEs must access multiple systems to acquire the information needed to perform a process. Both the business assessment and the technical assessment identified capabilities that would facilitate SMEs system access.
- *Unify UIs:* Making use of unified UIs is designed to supply all the data needed to support the SMEs' processes, no matter where the data resides. When asked in the business assessment whether this would be desirable, the response of the SMEs' was a decisive, yes. Additionally, such interfaces can provide consistent access to all users performing a similar function, no matter in which enterprise unit they work. To support such interfaces, real-time access is required.
- *Automate interfaces:* Real-time access to information in multiple systems that support Medicaid would prevent inconsistencies between systems and eliminate manual workarounds necessitated by current periodic transfers of data. Bi-directional updates are also an aspect of this theme. Business rules to ensure accuracy and preserve ownership of information would also need to be implemented.

- *Implement cloud computing:* This will allow for distributing software applications over high-speed Internet connections from remote data centers so that members, providers, staff, and other users can use them on any device with online access.

4.6.5 Business Results Condition

The Business Results Condition requires systems to support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public.

BA:

- *Streamline approval procedures:* Streamline approval procedures that are facilitated by a centralized availability of information, workflow management capabilities, and electronic approvals.
- *Improve the definition and application of performance measures:* This applies to measures articulated as part of contracts and measures to monitor the effectiveness of Commonwealth responsibilities.
- *Improve human capital***:** Human capital includes applicable technological skills and subject area expertise. It also includes ensuring staffing levels commensurate with enterprise priorities, the manual/automated nature of the process, ability to act proactively, and the effective monitoring of contracts QA.
- *Improve Commonwealth Contract and BRM capabilities:* including the development of MOUs with sister agencies. Most of these activities are manual in nature and many of the improvements discussed above will have an impact on the maturity of contract management and BRM business processes. This capability will be increasingly important as Pennsylvania expands its managed care population.

IA:

- *Implement a standardized data model:* Adopting an enterprise data model will better position the Commonwealth to adopt the national models and future data standards adopted by the MITA Framework.

TA:

- *Implement workflow management capabilities:* Pennsylvania has some workflow used to perform event tracking, but the majority of business processes rely on manual activities as well as systems automation. When considering movement of information across the enterprise, most business units have limited capability to electronically route files to businesses or individuals involved in the process. Automated workflow management systems can support electronic routing of data sets, send notices to users, and perform event tracking. Improved metrics would allow the PME to target resources to areas of opportunity. Business processes improvements will continue to be realized where identified activities and tasks can be measured and analyzed.
- *Implement electronic document management (EDM) capabilities:* Increasing the use of EDM would benefit virtually every aspect of Medicaid operations. The maintenance of critical documents using electronic systems can act as the single system of record. To achieve this, the capability should be available online for authorized users throughout the enterprise. This functionality would allow improved management of versioning, facilitate the sharing of information needed by multiple enterprise business processes, and provide a vehicle for distributed work management.
- *Improve the tracking and managing of agreements:* (e.g., MOUs, business associate agreements, data sharing agreements, etc.). Almost all agreements are missing termination dates and termination does not occur until either party agrees to terminate in writing. Some vendors are capable of automating the tracking and managing of some agreements; however, this needs to be prioritized by the

Commonwealth. This can be easily achieved by implementing workflow and document management capabilities.

4.6.6 Reporting Condition

The Reporting Conditions requires solutions to produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.

BA:

- *Implement a policy to establish forms management governance:* At present, data enters several DPW systems via manual data entry on hardcopy forms, online data entry, and electronic forms. There is no formal forms management across the enterprise. Establishment of standards for the creation and maintenance of both electronic and hardcopy forms as well as the designation of standard forms to use in relation to specific processes has the potential to simplify and streamline interactions between the enterprise and external stakeholders (clients, providers, and contractors).

IA:

- *Develop a standardized format for forms management:* Establishing a standardized format for forms management functions will ensure uniform management and retention of all data and documentation

TA:

- *Develop standardized electronic forms:* Establishing standardized online forms and a standardized central repository to store electronic documentation that is electronically entered or scanned, will allow for faster and easier access to documentation. At present, data is entered by manual data entry on hardcopy forms, some online data entry, and other electronic forms. Establishing a standard for the creation and maintenance of these forms, will help streamline interactions between the enterprise and other stakeholders.

4.6.7 Interoperability Condition

The interoperability condition ensures that seamless systems coordination and integration exists with the HIE and HIX (whether run by the State or federal government), and allows systems interoperability with public health agencies, eligible hospitals and eligible professionals enrolled in Pennsylvania EHR Incentive Program, human services programs, and community organizations providing outreach and enrollment assistance services.

As Pennsylvania increases it technical and information maturity, there are a few key functional considerations that must be included in planning and development. These considerations include:

- Pennsylvania should ensure that open interfaces are established and maintained with any federal data services hub
- Pennsylvania must test communications between exchanges and Medicaid systems so that determinations and referrals can be effectively transmitted
- Pennsylvania should continue to build a strategy of shared services development and how each service will support the exchange of data
- Pennsylvania should include a systems development path in all project charters to support interoperability with HIEs, public health agencies, and human services programs to promote effective customer service and better clinical management

As noted by both the business and technical assessments, while there are some processes that are highly automated, most business processes are still supported to some degree by manual activities. Automation of as many of these activities as possible will have a significant impact on the ability of enterprise staff to better address external stakeholder needs and program improvement. Several improvements were identified that would facilitate automation.

BA:

- *Leverage the outstanding feature(s) of enterprise systems.* There is an opportunity to explore the potential opportunities offered by a careful coordination of enhancements to PROMISe™, iCIS, HCSIS, COMPASS, and other systems to promote integrated operations.

IA:

- *Increased automation of interfaces with external entities* (e.g., national and federal databases, vital statistics, provider credentialing): Automation of interfaces with external entities can enable further automation of the process utilizing the interface, improve data accuracy, and reduce the timeframe necessary to complete the process. There are processes in most business areas that could be enhanced by implementation of these interfaces.
- *Implement enterprise-wide standardization of data:* This standardization of data should be implemented across all programs within the enterprise. Standardizing data will ensure that information can be interfaced with other systems and external entities that share the same data standards.

TA:

- *Expand implementation of electronic mechanisms:* Expanding electronic mechanisms to support interactions with and provide information to external enterprise stakeholders (providers, clients, and contractors) is essential to maturing enterprise processes. While some stakeholders welcome the move to electronic mechanisms, it was noted that many are resistant to these changes. SMEs cited improved training in areas such as Web Services Definition Language (WSDL) and Extensible Markup Language (XML) and incentives to encourage the shift to electronic mechanisms (e.g., email, website/web portal, and social media).

5.0 MITA Gap Analysis

5.1 Member Management

5.1.1 Management Area Strengths

The processes for the Member Management business function are primarily automated. The Commonwealth utilizes best practices such as the real-time CIS interface with PROMISe™ for claims processing and the web-based COMPASS self-service tool, increasing accuracy and availability of information. Due to the nature of the business processes, communications and grievance and appeals are more manual. The automated processes use fewer staff, generate better results, and facilitate inter-agency collaboration. This results in cost-effective practices, bringing higher benefits to the consumer, and allowing for more efficient use of resources. Strategies implemented by the Commonwealth to meet the requirements in the ACA and the Commonwealth's 5-year maturity goals will continue to improve automation and efficiency of the Member Management business area.

5.1.2 Internal Challenges

The Commonwealth faces barriers with system reliability, which cause time delays when enrolling members or changing pertinent information. The managed care logic in CIS is sometimes unstable and results in erroneous data or the omission of data, which requires manual intervention to correct. Additional challenges include limits of the antiquated MAPPER database and the outdated coding for CIS. These obstacles limit the effectiveness of the Member Management business function and slow down the overall process.

5.1.3 Opportunities for Addressing Maturity Gaps

The Commonwealth has opportunities to increase effectiveness, accuracy, and access for the Member Management business function. Improvements to functions in COMPASS will allow the population and members with Internet access to fully benefit from the program. The implementation of the ACA, MITA standards, and increased automation will provide improvements in capabilities. The Commonwealth will meet the initial ACA requirements by October 2013. These improvements will help to further automate the business function, reducing errors and increasing efficiency.

5.1.4 External Constraints

External pressures include budget constraints, legal challenges, statutory requirements, and regulations that will need to be reviewed, considered, and possibly revised to meet the 5-year To Be goals, e.g., the ability to accept electronic signatures prevents some business processes from full automation.

5.2 Financial Management

5.2.1 Management Area Strengths

There is an exceptional amount of data available in Medicaid enterprise systems. PROMISe™ and iCIS exchange information automatically, ensuring greater accuracy of data and allowing some processes to be automated (e.g., FFP for services processing). The staff in BIS provides prompt and useful assistance to staff in other units that use the EDW. Configurable business rules are available to users in PROMISe™ for some processes (e.g., benefit/reference information) and performance measures and reporting occur in some programs. The PROMISe™ financial cycle works well as an automated payables solution, requiring very little manual intervention when considering the volume of claims and payments being processed.

Audit and prepayment review processes validate legality and correctness of payments minimizing payment errors to less than one percent. Payments through the MMIS are very accurate and the payment data is available as needed. Payments outside of MMIS are closely monitored by the program offices through their Commonwealth oversight processes.

The close partnership between HPES, Unisys, and the Department's Pharmacy staff works well to ensure; accurate invoicing, dispute resolution, and reporting for maximizing Pennsylvania Medicaid's federal drug rebates. MCOs, HPES, the Pharmacy Unit, and Unisys have worked well together in implementing the process for MCO rebates.

5.2.2 Internal Challenges

There are a number of challenges that impact most Financial Management business processes including the predominance of manual business process steps. Documentation and information is primarily non-standardized, stored in disparate systems, and is not easily accessible. This results in staff spending a lot of time manually verifying and reconciling information gathered from multiple points in the Enterprise. The EDW is not organized in a manner that facilitates use by the average end-user nor does it currently contain a full set of program information. Query capabilities are strong, but many users do not understand the nature of the data. Metadata definitions have limited or no usefulness. Reliance on the expertise of PME staff presents a risk to the organization when these individuals leave the organization and a lack of measures to monitor performance and business activity limits management's ability to acquire a clear picture of the "state" of the Medicaid program and act proactively.

For Treasury, the TABS is one of several siloed systems used from the beginning of the pre-payment review process to the actual physical disbursement of the payment. Treasury is in the process of designing and implementing a new PeopleSoft Enterprise Resource Planning (ERP) system to circumvent these issues.

Waiver programs at the county level currently do not fully use PMA business processes for service authorization and payment. For these programs, waiver-related information is received electronically requiring manual interaction outside of the MMIS. HCBS programs are separated and uncoordinated, and payments are generally non-standard and cover a variety of atypical providers.

There are no inbound files from Treasury (e.g., warrant file) to the PROMISe™ system to update payment info in PROMISe™ when payments fail to issue from Treasury as intended. The PROMISe™ reconciliation in this regard is manual and involves differing operational processes based on the circumstances of the issued payment failure. These operational processes may take 3 weeks on average from the intended payment issue date to be completed.

Existing budget models in Excel format are updated and used to analyze the budget data stored in disparate systems. The extraction of budget data from these disparate systems often makes data analysis difficult due to inconsistencies in data definition.

5.2.3 Opportunities for Addressing Maturity Gaps

The Commonwealth has several opportunities it can pursue to improve current Maturity Levels within the Financial Management business process area. These opportunities include implementation of a financial module that centralizes the functions of payment processing and data storage to enhance the potential for greater system interoperability. The following examples more specifically address opportunities for MML advancement:

- Treasury is in the process of designing and implementing a new PeopleSoft ERP system to circumvent the issue of having to use disparate systems to complete payment processes in the TABS system. The actual implementation date is not known at this point in time.
- Create and enforce a new Provider Agreement which will provide continuum of care for HIPP program participants (FFS vs. MCO) and develop a client participation (cost sharing) process where the client financially participates in their healthcare costs
- The PROMISe™ and SAP workflows are not integrated and cannot share attachments related to supporting accounting documentation. This requires documentation to be emailed from within the PME to Comptroller Operations and from Comptroller Operations to Treasury.
- There are technological automated process offerings available that are not currently being taken advantage of by other system components or the various bureaus within the Enterprise e.g., e-signature. There are advancement opportunities for business process re-engineering.
- The Financial module must be supported by either a centralized data store or federated data model. The "Pay To" entity for any payments must be supported by accounts payable/accounts receivable where any payment can be traced back to the source. This should also include the payee information and payment reason information.
- The financial module must be web-enabled to allow statewide access to authorized users. The module must support role-based access (providers would have a different access level than a Commonwealth staff analyst).
- The 1099 business process must provide the ability to post 1099 details on a provider/vendor web portal. Data matching capabilities will improve through the use of better data collection tools and better maintenance and standardization of data across the PME to eliminate the need to manually verify 1099s prior to releasing them for distribution e.g. the use of a federated financial module that combines all 1099 processes into a single system and process (SAP vs. PROMISe™).

5.2.4 External Constraints

The Commonwealth currently faces several challenges outside the control of the Enterprise that impact Financial Management business processes. The data contained in the CMS quarterly drug rebate file and annual rate reviews is not always accurate (e.g., termination dates and DESI codes) and causes the process to dependent entirely upon the manufacturers' reported data.[14] Data sharing with external agencies can be difficult as the data is inaccurate or the agency is unwilling to provide the data.

The DOH/MHS Manage Drug Rebate process is similar to that of the Manage Drug Rebate process performed by DPW. The Manage Drug Rebate business process could easily be merged into one Enterprise system and one Enterprise process. However, DOH client-eligible pharmacy benefit programs are also non-Medicaid eligible. Without a sustainable funding source to facilitate the transfer of non-Medicaid eligibles and the drug rebate management processes over to OMAP, DOH must devise a way to reimburse DPW for these PBM services.

SSA and CMS rules govern the cost of member premium payments. The PME cannot effectuate changes to the cost of premiums to make the process more cost-effective. In addition, delay in delivery of CMS and SSA interfacing files constrain the ability of the PME to realize further efficiencies in process duration.

CMS guidance related to federal reporting changes is often untimely in that insufficient time is permitted to implement the necessary changes into PROMISe™. The result is a need on the part of the Comptroller to manually crosswalk the system-applied account coding to the appropriate lines on the CMS-64 until changes can be implemented in PROMISe™.

[14] FM04 Manage Drug Rebate

Constraints outside of the Commonwealth's control that have an impact on Financial Management business processes include CMS data exchange requirements that currently limit what can be automated (e.g., receipt of some standard codes, CMS-64 reporting mechanism, State Plan process). State and federal requirements impose procedures and timeframes that are outside the control of the PME (e.g., State Plan process, Commonwealth budget process) and cultural constraints that prevent full implementation of electronic mechanisms cannot be ignored.

5.3 Operations Management

The strength of the Operation Management business processes starts with the PROMISe™ system. This system, for the most part, meets the needs of the stakeholders involved. The Commonwealth has implemented all mandated HIPAA standard transactions.

5.3.1 Internal Challenges

The major internal challenges relate to timeliness of rate and contract changes. These delays result in increased mass adjustment of claims and extra work on the provider's end to reconcile payments. In addition, the waiver program rate changes require manual workarounds. Improving the timeliness of the process would greatly improve the overall efficiency.

5.3.2 Opportunities for Addressing Maturity Gaps

There are several opportunities that the Commonwealth can address to improve the MML of the Operations Management business processes. These opportunities include the ability to easily implement and maintain edit rules and criteria. Other opportunities include increasing the use of electronic attachments and modifying the encounter process to stop while access to the recipient file is unavailable.

5.3.3 External Constraints

Constraints outside of the Commonwealth's control that have an impact on Operations Management business processes include access to EHRs (to utilize clinical data), the provider use of electronic attachments, provider acceptance of ERA to reduce or eliminate paper statements, and the MCOs providing good encounter data.

5.4 Business Relationship Management

5.4.1 Management Area Strengths

Electronic exchange of information used in Business Relationship Management processes allows for efficiency. Additionally, data exchanges with the MCOs and other contracted entities are well defined and appropriate protocols have been established. The HealthChoices intranet website is a useful tool for these processes.

5.4.2 Internal Challenges

Business Relationship Management processes do face internal challenges such as the manual nature of the processes, as well as the lack of consistent standards for data sharing with outside entities. This results in slow and manual processing as well as potential interruption of the processes.

5.4.3 Opportunities for Addressing Maturity Gaps

There are opportunities that will address the maturity gaps in the Business Relationship Management business area, which include implementation of a web-based business relationship management tool including workflow and document management functionality, system interoperability with other entities including the HIE and public health agencies, and implementation of e-Signatures.

The contract administration process can be improved through a centralized data and a standard process. This would improve timeliness, efficiency, and cost-effectiveness.

5.4.4 External Constraints

External constraints include the approval process (including approvals needed for terminations) and bureaucratic intervention. These constraints have the potential to result in untimely processing.

5.5 Contract Management

5.5.1 Management Area Strengths

There are pockets of excellence within some program areas of the Contractor Management business function. Some standard templates and terms and conditions are used. The staff involved in the Contractor Management process work together effectively to produce results. The Commonwealth has successfully defined a strategy for implementing improvements to meet 5-year maturity goals.

5.5.2 Internal Challenges

Efficiency, cost-effectiveness, and accuracy of results for each process are dependent on multiple factors including the program office involved, resource experience, technical accuracy, and the availability of data. The inconsistencies across the program offices directly impact utility and value to stakeholders. Overall, the Contractor Management business function is not cost-effective due to inconsistencies across the process.

5.5.3 Opportunities for Addressing Maturity Gaps

The Commonwealth has opportunities to increase effectiveness, accuracy, and access for the Contractor Management business function as MITA and Enterprise standards are developed and implemented. Numerous goals have been established to be met within 5-years that will fully automate the business function, reducing errors and increasing efficiency. These goals will allow the Commonwealth to request additional funds as its MML increases.

5.5.4 External Constraints

External pressures include budget constraints, legal challenges, statutory requirements, and regulations that will need to be reviewed, considered, and possibly revised to meet the 5-year To Be goals. Further, the Commonwealth will be constrained by the development and adoption of a MITA national standard for all nine MITA business processes in the Contractor Management business area.

5.6 Provider Management

5.6.1 Management Area Strengths

The Provider Management business area functions are primarily automated; however, communications and outreach are more manual due to the nature of the business process. The business area will gain

maturity as advancements needed for the implementation of ACA are instituted. Data availability will increase and automated interfaces and screening requirements will provide assurances of greater accuracy. Additionally, the capture of more granular information (such as risk level, credentials, etc.) will allow the Commonwealth to manage and target communications in a cost-effective and efficient manner.

The systems and/or processes involved in the Provider Management business area are PROMISe™, PEAP/ePEAP Scanning and Workflow, FADS, and the Provider Portal, utilizing several data stores including the MPI and EDW, with interfaces to internal and external entities for data collection, validation, and verification.

5.6.2 Internal Challenges

The Commonwealth identified internal challenges within the Provider Management business area. Listed below are the most significant challenges that were identified during the Medicaid Enterprise surveys and business process reviews.

- Provider data management requires resolving data ambiguities and interpretation issues that result in data inconsistencies. Opportunities for data management include the implementation of a central provider data repository, compliance with health care industry data standards, data exchange standards, and HIPAA privacy and security regulations.
- Process automation would reduce or eliminate the use manual activity necessary throughout the Provider Management business area. Currently, provider outreach and communication processes within provider management are predominately manual with a few automated processes. Follow-ups are incomplete, fragmented, or non-existent. Notification of disenrollment outcomes, procedural rights information access, provider enrollment policy materials distribution, and letters result in return mail and no assurances of delivery.

5.6.3 Opportunities for Addressing Maturity Gaps

Advancement opportunities are available through the implementation of the initial ACA requirements, targeted for October 2013. Possible improvements can be made by taking advantage of existing conditions such as federal funding, collaboration and consolidation of resources, elimination of silos, and leveraging other systems and data stores for provider information.

5.6.4 External Constraints

Issues and/or tasks that would prohibit or delay the progression of this business process through the MMLs includes budget constraints, staffing constraints, siloed work processes, prohibitive regulations, and statutory requirements.

5.7 Performance Management

5.7.1 Management Area Strengths

Performance Management activities performed by the Commonwealth are well documented and supported by effective automation, which increases the accuracy of the results and the efficiency of the processes. Data is primarily electronic.

5.7.2 Internal Challenges

Performance Management business processes face internal challenges when there is a turnover of experienced resources. When this occurs, cost-effectiveness is impacted.

The staff, at times, may be inundated with requests. This limits the time spent on proactive projects. A workflow tool may assist in categorizing, assigning, and tracking the requests.

5.7.3 Opportunities for Addressing Maturity Gaps

Performance Management is identified as a key area for systems enhancements. These initiatives will need to ensure a comprehensive data collection and management approach as well as a user-as-customer focus.

The Recipient Explanation of Medicare Benefits (REOMB) process can be improved by utilizing automation such as the scanning of returned REOMB forms and the elimination of bad addresses. Once scanned, the REOMB forms can be tracked to manage the review of each form. The sampling process could also be improved to target selected populations.

5.7.4 External Constraints

External constraints include the availability and responsiveness of external agencies. Resource constraints including budgetary restrictions and staff turnover directly impact the efficiency and effort required.

The Department experiences a relatively low REOMB response rate from the members.

5.8 Care Management

The Care Management business processes are conducted by various business units within, and outside of, the Medicaid Enterprise. Consistent integration, data standards, and data exchange interfaces are lacking and create barriers to efficient processes. Predictive modeling is no longer available for analytics and planning by Commonwealth staff. The DOH also provides some Care Management business processes; Manage Registry is housed solely at DOH. The integration of any DOH business processes into the Medicaid Enterprise requires a sustainable funding source to include it in the Enterprise initiative.

5.8.1 Management Area Strengths

More than 80 percent of Pennsylvania's Medicaid population is covered by an MCO. Pennsylvania's MCOs are required by contract to provide their own case management.

Bureaus within the Enterprise that are involved in the process work well together. Interfaces between HCSIS and PROMISe™ for claims adjudication and between SAMS and HCSIS to support claims validation comprise the majority of data in this business area. CaseNet works well for Commonwealth staff. It houses assessments, care plans, and documentation. CaseNet provides triggers for reviews and also documents acuity levels.

5.8.2 Internal Challenges

Although roughly 20 percent of the population is still on FFS Medicaid, the Commonwealth no longer has a predictive modeling tool to assist with managing their cases. Both the SAMS and HCSIS are old systems that require upgrades.

The Care Management internal challenges are due in large part to a lack of an Enterprise-wide collaboration. Issues for resolution include the addition of a workflow, automation, standardization of data and interfaces, and the lack of a predictive modeling tool.

5.8.3 Opportunities for Addressing Maturity Gaps

The following opportunities are available to the Commonwealth to improve business process Maturity Levels:

- Governance/Policy/Ownership – The foundational task for governance is the collaboration of all care management stakeholders within the Enterprise to define all data and data needs for the business area, determine proper workflow, and ensure Federal and Commonwealth initiatives are implemented and maintained
- Care Management Data Management – Utilize and comply with all care management data standards, MITA standard interfaces, and HIPAA data privacy and security regulations
- Care Management Workflow – An automated workflow would reduce manual processes, thus reducing the time it takes for a member to receive care

5.8.4 External Constraints

Some MITA-identified constraints that could restrict and/or delay the progress of this business area through the MMLs include political and/or lack of interagency coordination mechanisms, including the ability to share data across Department lines and conflict over the appropriate use of health care information. Limited, authorized data access restricts users from accessing information for evaluation of the Commonwealth's Medicaid population and to develop stakeholder satisfaction monitoring and reporting.

5.9 Health Plan Management

5.9.1 Management Area Strengths

There is a large amount of data available in the Medicaid enterprise systems. The PROMISe™ and iCIS, systems exchange data real time improving the accuracy of the data exchanged. The BIS staff provides assistance to the staff in other units with the use of the EDW. Configurable business rules are available to users in PROMISe™ for certain processes (e.g., benefit/reference information) and performance measures and reporting occur in some programs.

The existing processes are thorough and PMA is very responsive in managing requests. The various groups involved meet regularly which helps the process be timelier. The existing data systems are able to supply the information needed for the processes.

5.9.2 Internal Challenges

There are a number of challenges that impact most Health Plan Management business processes including a predominance of manual business process steps. The information is stored at disparate locations and is not easily accessible resulting in the manual verification and reconciliation of information gathered from multiple points in the PME. The EDW is difficult to use for the average end-user and it does it currently contain a full set of program information. Query capabilities are strong, but many users do not understand the nature of the complex data. The program relies on the expertise of EDW staff to understand the data and build the appropriate queries. This creates a risk to the organization when staff turnover occurs. The loss of these individuals limits management's ability to acquire a clear picture of the "state" of the Medicaid program and act proactively.

5.9.3 Opportunities for Addressing Maturity Gaps

There are a number of capabilities already in use by some units within the PME that, if expanded, could have a large impact on improving Maturity Levels for many Health Plan Management business processes such as data analysis tools, automated workflow capabilities, electric document management, and user configurable business rules. Standardization of data definitions across the PME would reduce the need to verify information, support direct system to system exchange of information, and allow more process steps to be automated. Additional opportunities include continuing to increase the use of electronic mechanisms in the exchange of information (e.g., leveraging the Provider Portal to distribute 1099s to providers, reducing the need for paper and postage) and expanding the use of performance measures, as they will be key to demonstrating to CMS that the maturity improvements identified as To Be goals have been achieved. This will support the next round of requests for funding.

5.9.4 External Constraints

Constraints outside of the Commonwealth's control that have an impact on Health Plan Management business processes include CMS data exchange requirements that currently limit what can be automated (e.g., receipt of some standard codes, CMS-64 reporting mechanism, State Plan process). Commonwealth and federal requirements impose procedures and timeframes that are outside the control of the Medicaid Enterprise (e.g., State Plan process, Commonwealth budget process) and cultural constraints that prevent full implementation of electronic mechanisms cannot be ignored.

5.10 Eligibility and Enrollment Management

5.10.1 Management Area Strengths

The process steps for the Eligibility and Enrollment Management business area are accomplished through a mix of manual and automated tasks. The automated processes use fewer staff, generate better results, and facilitate interagency collaboration. This results in cost-effective practices, bringing greater benefits to all stakeholders.

For the Eligibility and Enrollment processes that involve members, the managed care logic in CIS that enrolls recipients and batch programs that generate files functions well. COMPASS is increasingly used and its capabilities permit staff more time for other tasks. Interfaces and automation increase accuracy and timeliness. Real-time eligibility transactions are used during claims processing. For the business processes that involve providers, workflows, scanning and the provider portal have helped to streamline business process steps. Interfaces with licensing offices have provided the Commonwealth with more accurate validation of provider data.

Strategies implemented by the Commonwealth to meet the requirements in the ACA and the Commonwealth's 5-year maturity goals will continue to improve automation, collaboration, and efficiencies of the Eligibility and Enrollment business area.

5.10.2 Internal Challenges

The Commonwealth faces barriers with system reliability, which cause time delays when enrolling, disenrolling, or updating pertinent information for providers and recipients. The manual data entry and paper data sources used in many business processes can result in erroneous or omitted data, which requires manual intervention to correct. Additional challenges include lack of interfaces and collaboration with other entities.

5.10.3 Opportunities for Addressing Maturity Gaps

The Commonwealth has opportunities to increase effectiveness, accuracy, and access for the Eligibility and Enrollment Management business area. Improvements to functions in COMPASS will allow the population and members with Internet access to fully benefit from the program. The implementation of MITA and Enterprise standards and tracking will improve interfaces and collaborative efforts, thus streamlining tasks for added accuracy and cost-effectiveness. Taking advantage of existing conditions such as federal funding, collaboration and consolidation of resources, elimination of silos, and leveraging other systems and data stores will help advance maturity for provider business processes within the business area. The Commonwealth has established numerous goals to meet within 5-years that will automate the business area to the greatest extent possible. The completion of these goals, in addition to planned upgrades needed to support the ACA will advance the Maturity Level of many of the business processes.

5.10.4 External Constraints

External challenges to maturity advancement include Commonwealth access to the National Provider Sanction and Exclusion list. Access would ensure the investigation of providers that have records in other states. Additional interfaces with other states would enhance data verification and validation of provider data to better serve the Commonwealth. Additional challenges include budget constraints, legal challenges, statutory requirements, and regulations that will need to be reviewed, considered, and possibly revised to meet the 5-year To Be goals. Further, the Commonwealth will be constrained by the development and adoption of a MITA national standards pending further guidance from CMS.

6.0 MITA ROADMAP

6.1 Overview

The strategic initiatives and modules included in this MITA To Be Roadmap are structured to meet the conditions and standards approach as outlined by the CMS in its April 2011 MITS entitled Enhanced Funding Requirements: 7C&S[15]. The Commonwealth understands that several federal initiatives and requirements must be addressed over the next 5-years and intends to leverage these requirements, as well as existing projects and IT assets to promote a modular and MITA aligned approach to systems implementations. A key driver will be timing the enhancements and replacement systems around current contracts and procurement cycles. The activities necessary to solicit, contract, enhance, or implement each enterprise module were considered in this Roadmap.

This MITA 3.0 To Be Roadmap provides a foundation for the detailed project and module descriptions required for federal funding requests. For the Medicaid Enterprise and this Roadmap, Pennsylvania considers the DPW, the PDA, the PID –SCHIP, and the MCOs that support these agencies to be its Tier 1 organizations. The Tier 2 organizations include the DOH and the DMVA. This 5-year outlook focuses on the Tier 1 agency projects.

In this section, the Medicaid Enterprise agencies are seeking CMS' approval of the initiatives on the Roadmap. Upon CMS approval of the deliverable and availability of resources (both monetary and staffing), the Enterprise will submit individual project APDs to request enhanced funding from CMS for priority projects included in this plan.

Each strategic initiative or module in this Roadmap serves to improve the maturity of multiple MITA business processes. The Commonwealth will seek opportunities to modularize its systems either through state/federal initiatives, other system projects, or through procurements. However, the Commonwealth must work within the constraints of limited funding, staffing resources, and risk to programs in determining when to modularize functions.

As part of the APD process, CMS expects all states to prepare and submit a MITA 3.0 Roadmap and to complete and continue to make measurable progress in meeting the goals of its Roadmap. CMS also expects:

- The MITA 3.0 Roadmap to cover a 5-year outlook and address:
  - Goals and objectives
  - Key activities and milestones
  - Proposed system solutions
  - How the state plans to improve in MITA maturity over the 5-year period and their anticipated timing for full MITA maturity
- The SMA to update the MITA 3.0 Roadmap document on an annual basis
- States submitting partial system updates to submit and have an approved MITA To Be Roadmap for achieving full compliance with 7C&S to receive enhanced FFP

CMS will track progress against an approved Roadmap when determining if system updates meet CMS's 7C&S for the enhanced match. States must ensure that they have a sequencing plan that considers cost, benefit, schedule, and risk. States must also ensure that their BA conforms to the Commonwealth's COO and BPM.

[15] Source: Enhanced Funding Requirements : Seven Conditions and Standards; Medicaid IT Supplement (MITS-11-01-v1.0); http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf

The MITA To Be Roadmap must include the following key elements as described in the table below.

Table 38: Key Elements for the MITA Roadmap

MITA Roadmap Component	Component Description
Statement of Goals and Objectives	Includes a statement of purpose, including vision, program needs, objectives and anticipated benefits, and compliance with regulations. It should also identify any state workgroups or collaborative efforts.
Project Management Plan	Summarizes how the SMA plans to assess its As Is operations and To Be State Medicaid Enterprise environment. It briefly describes the planning project organization and describes how the SMA will conduct the activities for planning, as well as the schedules and milestones for completion of key events.
Proposed Project Budget	Describes the resource needs for which the SMA may request funding support. These needs may relate to personnel costs, resources, and contractor costs for staff, equipment, facilities, travel, outreach and training.

The PME plans to continue aligning its strategic systems planning with MITA and 7C&S over the next five to ten years. This planning includes increasing the use of SOA and a modularization of the business processes for a component driven approach to designing enterprise systems business functionality. The goal of this modularity is to create an architecture that, over time, allows changes to individual system modules to be completed in less time, for less cost, and more efficiently.

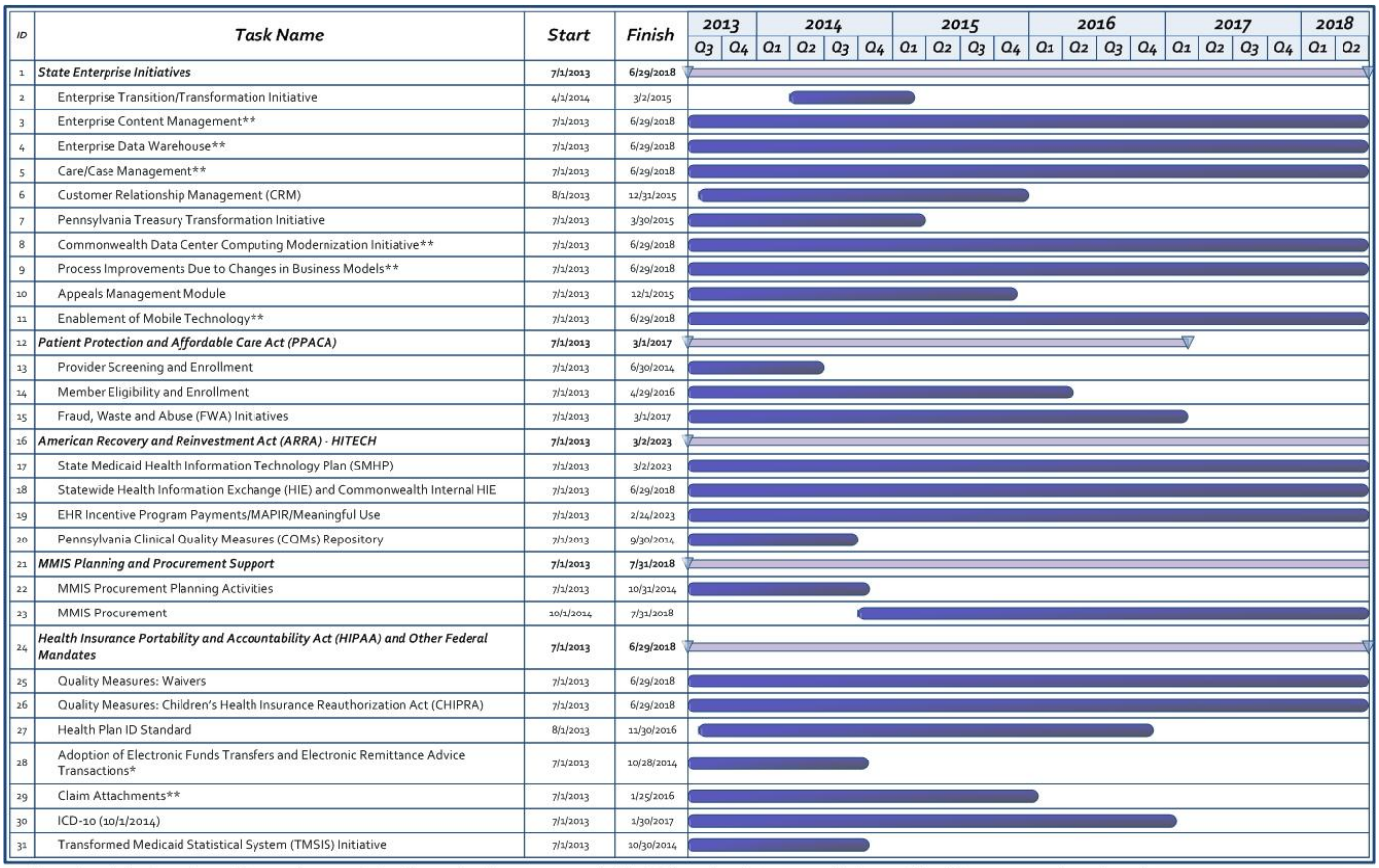
The Gantt chart in Figure 18 provides an illustration of the current projects included in the Pennsylvania MITA To Be Roadmap. The Pennsylvania initiatives are organized in the following five high level categories:

- State Enterprise Initiatives
- PPACA
- Health Information Technology for Economic and Clinical Health (HITECH)
- MMIS Planning and Procurement Support
- HIPAA and Other Federal Mandates

The projects included in this Roadmap have been developed to meet the requirements of 7C&S. While the chart is meant to provide a timeline of existing and planned projects, DPW will use this timeline, funding constraints, resource availability, consolidation of redundant systems, and other drivers to determine the specific order of implementation.

As noted in the Executive Summary, the PME has successfully completed several of the projects included in the June 2011 Pennsylvania MITA To Be Roadmap. Additionally, Pennsylvania has made progress in improving the Maturity Level of several business processes with the implementation of or planning for specific enhancements and initiatives. Updates to these are noted within the appropriate sections of the Roadmap projects and initiatives, along with project descriptions that correspond to the Pennsylvania Roadmap Gantt chart that is displayed in the following figure.

Figure 18: Roadmap Gantt Chart



ID	Task Name	Start	Finish
1	***State Enterprise Initiatives***	**7/1/2013**	**6/29/2018**
2	Enterprise Transition/Transformation Initiative	4/1/2014	3/2/2015
3	Enterprise Content Management**	7/1/2013	6/29/2018
4	Enterprise Data Warehouse**	7/1/2013	6/29/2018
5	Care/Case Management**	7/1/2013	6/29/2018
6	Customer Relationship Management (CRM)	8/1/2013	12/31/2015
7	Pennsylvania Treasury Transformation Initiative	7/1/2013	3/30/2015
8	Commonwealth Data Center Computing Modernization Initiative**	7/1/2013	6/29/2018
9	Process Improvements Due to Changes in Business Models**	7/1/2013	6/29/2018
10	Appeals Management Module	7/1/2013	12/1/2015
11	Enablement of Mobile Technology**	7/1/2013	6/29/2018
12	***Patient Protection and Affordable Care Act (PPACA)***	**7/1/2013**	**3/1/2017**
13	Provider Screening and Enrollment	7/1/2013	6/30/2014
14	Member Eligibility and Enrollment	7/1/2013	4/29/2016
15	Fraud, Waste and Abuse (FWA) Initiatives	7/1/2013	3/1/2017
16	***American Recovery and Reinvestment Act (ARRA) - HITECH***	**7/1/2013**	**3/2/2023**
17	State Medicaid Health Information Technology Plan (SMHP)	7/1/2013	3/2/2023
18	Statewide Health Information Exchange (HIE) and Commonwealth Internal HIE	7/1/2013	6/29/2018
19	EHR Incentive Program Payments/MAPIR/Meaningful Use	7/1/2013	2/24/2023
20	Pennsylvania Clinical Quality Measures (CQMs) Repository	7/1/2013	9/30/2014
21	***MMIS Planning and Procurement Support***	**7/1/2013**	**7/31/2018**
22	MMIS Procurement Planning Activities	7/1/2013	10/31/2014
23	MMIS Procurement	10/1/2014	7/31/2018
24	***Health Insurance Portability and Accountability Act (HIPAA) and Other Federal Mandates***	**7/1/2013**	**6/29/2018**
25	Quality Measures: Waivers	7/1/2013	6/29/2018
26	Quality Measures: Children's Health Insurance Reauthorization Act (CHIPRA)	7/1/2013	6/29/2018
27	Health Plan ID Standard	8/1/2013	11/30/2016
28	Adoption of Electronic Funds Transfers and Electronic Remittance Advice Transactions*	7/1/2013	10/28/2014
29	Claim Attachments**	7/1/2013	1/25/2016
30	ICD-10 (10/1/2014)	7/1/2013	1/30/2017
31	Transformed Medicaid Statistical System (TMSIS) Initiative	7/1/2013	10/30/2014

** Indicates the majority of compliance with EFT and ERA standards will be completed by Jan. 1, 2014 and will be in full compliance in Sept. 2014 with the completion of the Treasury Transformation Project.*
*** Indicates the actual Project Start Date and/or Project Finish Date is still to be determined. For most of these projects, the Start Date shows 7/1/2013 and the Finish Date is 6/29/2018 and is subject to change.*

The Pennsylvania MITA To Be Roadmap may be subject to changes resulting from the release of future MITA framework updates, state and federal fiscal impacts, and other future constraints such as availability of MITA national standards.

6.2 Enterprise System Strategy

As previously noted, the PME plans to align with MITA principles for new Enterprise systems design, including increasing the use of SOA, rules engines, and business process modules for an overall service driven approach. The SOA framework uses business processes and/or service components logically grouped together to deliver a well-defined level of service that promotes sustainability and re-use, and facilitates the delivery of a flexible, agile, and interoperable Enterprise.

The Commonwealth's Enterprise Project Management Methodology (EPMM) is the framework used to manage overall IT project development and ensure that new projects meet business and technical standards. As new components to existing systems are proposed, the appropriate EPMM will apply the MITA framework to those components.

DPW consolidated the IT functions previously distributed in multiple program offices under one agency-wide BIS. This approach to IT has allowed DPW to develop a suite of systems and services which effectively support multiple departments within Pennsylvania.

The move to modularity by the PME has been demonstrated through successful initiatives such as the MPI, the MCI, and MAPIR.

- **MPI** is the Department's central repository of provider profiles and demographic information that registers and uniquely identifies providers that do business with DPW. MPI includes HCBS Waiver providers, Low Income Home Energy Assistance Program (LIHEAP) fuel vendors, childcare providers, and MA providers, supporting the DPW's Enterprise applications, and services for multiple program offices.
- **MCI** is a central repository for consumer demographic data to allow DPW to uniquely identify consumers who are participating in programs, including those receiving services across multiple program offices. MCI provides opportunities to better serve consumers and improve program and information reporting through streamlined consumer registration, as well as improved fraud and identify detection.
- **MAPIR** is an Internet based application that was developed by a 13-state collaborative, led by Pennsylvania DPW, using open source products to support the processing of EHR PIPs. The core MAPIR application, that is modular and integrated into an existing provider portal and financial system, is shared with all states. The cost of developing the MAPIR application was shared across collaborating states, significantly reducing the cost that each state would spend to implement a system to support this program, aligning with the Leverage Condition.

DPW has also developed shared modular IT components to support the business logic across multiple IT functions and program areas. DPW developed a host of shared Enterprise services to perform a range of common functions including business-oriented functions, such as maintaining consumer and provider data, application submission services, PDF document creation and file storage utilities, and security controls architecture services. Use of these shared services is encouraged across the Enterprise.

Existing contracts need to be modified to align with the MITA framework as they come up for procurement. For example, under MITA, with its emphasis on SOA, the opportunity exists to reduce the risk of implementing an all-inclusive MMIS by breaking it up into its component parts. It would be impractical to assume a fully modular MMIS as there is no proven system available today that offers such functionality. Such an attempt may actually result in an increased risk factor relative to a complete Enterprise systems replacement. DPW's current approach is to start the process of moving toward SOA by modularizing a single MMIS component that already has significant standards defined, such as provider. That could eventually result in an overall improved SOA model for the Enterprise systems.

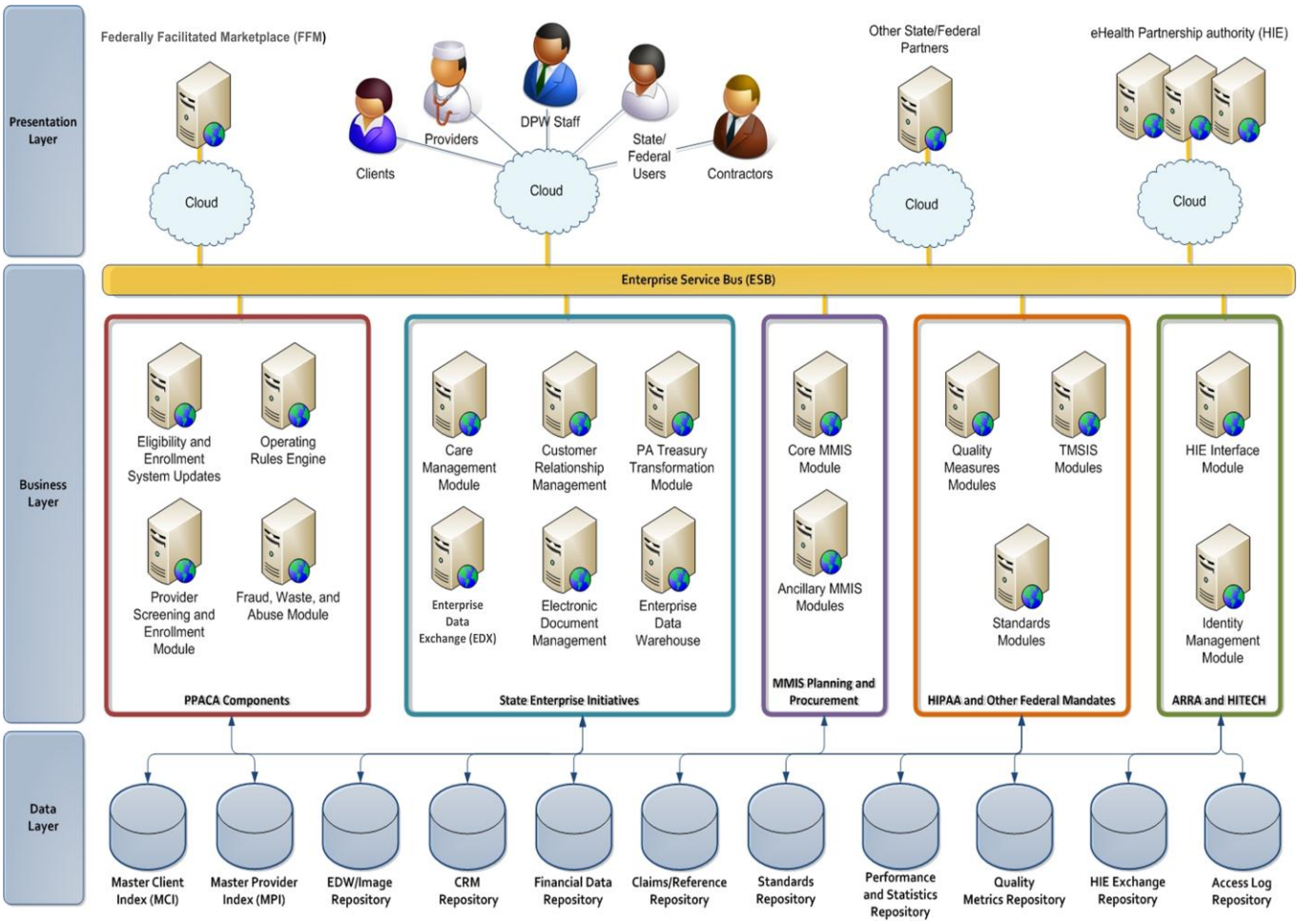
Implementing modules that act as distinct units, or services, versus the monolithic systems being implemented today, substantially reduces risk and lowers the cost of a complete replacement for the following reasons:

- Individual modules can be enhanced or replaced as needed without replacing the entire Enterprise component
- While modules communicate with each other, they are no longer interconnected. As such, replacing a particular module does not have the potentially troublesome downstream effects on other modules. With the current system, making changes within a particular subsystem can have unintended consequences throughout other subsystems.
- Through modularity, states can create a structure that, over time, allows changes to individual modules to be completed more quickly, cheaply, and efficiently

The figure below provides a conceptual model of the Enterprise systems necessary to support the Commonwealth To Be Roadmap in the future. The architecture reflects a target SOA environment, but

may result in a mix of mainframe and client server environments. Each of the components and modules is grouped within the five project categories outlined in the MITA Roadmap section.

Figure 19: Conceptual Model



6.2.1 Project Management

For a majority of the projects and initiatives on this Roadmap, project management will be executed under the established EPMM project governance structure to monitor progress during the project life cycle. This project governance structure provides a foundation for the organized and consistent planning and execution of projects whether the work is performed by Commonwealth staff or with contractor support.

The project governance used is a six-team structure. These six teams consist of the Steering Team, Project Management Team, Development Team, Testing Team, User Education Team, and Logistics Team. The following defines the roles and responsibilities that project teams perform during a project.

Steering Team

The Steering Team articulates a vision for the product or service, acquires and quantifies high-level customer requirements, develops and maintains the business case, and manages customer expectations. Its role is to ensure that business expectations are clearly articulated and understood by all stakeholders and other project governance teams, and to ensure the functional specification responds to business priorities. The Steering Team must also facilitate the rapid resolution of issues and decisions that cannot be agreed upon or resolved among the other project governance teams. The Steering Team is responsible for ensuring that the project follows Commonwealth and Department technical, policy, quality standards, and procedures.

Project Management Team

The Project Management Team drives the critical decisions necessary to ensure product delivery, according to scope and the Steering Team's direction, at the right time, and within the project's established resource constraints. The Project Management Team clarifies the business case, identifies the detailed project requirements, integrates the efforts of each functional team engaged on the project, drives core project-level decisions requiring integration across the other project governance teams, and manages all subordinate teams' resources and roles.

Functional Project Teams

Development Team

The Development Team designs, codes, and implements a quality product or service that meets the specification and customer expectations. The Development Team validates potential solutions through input to design, technology evaluations, and proof-of-concept prototypes, estimates time and effort to complete the design and product build, and serve as a technical consultant.

Testing Team

The Testing Team ensures all issues are known before the product or services release. The Testing Team evaluates and integrates the IT product and deliverables, validates whether project requirements have been satisfied, the product conforms to the project's specifications, develops test strategies, plans, and scripts, and conducts tests

User Education Team

The User Education Team enables users to maximize the product or service through performance solutions such as job aides, Frequently Asked Questions (FAQs), online help, and education systems.

Logistics Team

The Logistics Team ensures that a product or service is rolled out, installed, and implemented smoothly during the operations support phase. The Logistics Team serves as an advocate for operations, product support, help desk, and product delivery channels, ensures that the product will be deployable and maintainable, and product installation sites have the appropriate IT infrastructure.

6.3 State Enterprise Initiatives

The projects and initiatives in this section represent specific Pennsylvania efforts to better align with MITA and 7C&S. Each of the following projects and initiatives addresses the timeframe, goals and objectives, project management approach, and the proposed budget for the project being described, if known. A table at the end of each subsection identifies the key MITA business processes that are impacted by the project or initiative.

6.3.1 Enterprise Transition/Transformation Initiative

Duration:
Projected: April 2014 – March 2015

Description:
The PME recognizes the need for project management expertise and a project governance structure to manage a variety of prioritized project enhancements and business process improvements throughout the Enterprise. The success of all prioritized projects conveyed in this Roadmap, including maintenance updates to the MITA SS-A document, is dependent upon:

- Enterprise governance
- Cooperation from stakeholders
- Skilled staffing to support and supplement project management and support

In addition, the degree of collaboration between vendors and the Enterprise governance and review teams will contribute substantially to the success of these projects.

The most notable challenge for the Enterprise will be its ability to manage new architectural structures under MITA, with its emphasis on SOA and modularity, robustness, and flexibility, and alignment with its strategic priorities and vision. All new procurements, whether it is a total replacement or enhancement, must subscribe to the architectural features of MITA and 7C&S.

Pennsylvania plans to transform the existing project governance processes into a formal governance structure for the Enterprise as it embraces MITA. This project will bring on focused, dedicated resources for a period of time to transform the existing project governance structure and implement the cultural change management needed to operate as an Enterprise.

This project will work to establish an Executive Steering Committee and a Project Management Team to manage the various projects to ensure standardization and alignment with the MITA framework. The Enterprise governance will establish the appropriate levels of management oversight to monitor project progress and assess contractor performance for each related enhancement and business process improvement during the project life cycle.

It is expected that this Enterprise governance structure will expand to the DOH and potentially to the PID for SCHIP as the MITA To Be Roadmap progresses.

Goals and Objectives:
The primary goal of this initiative is to formally establish an Enterprise governance structure to oversee prioritization and coordination of projects, architectural changes, data governance, and standards and process changes across the PME.

Objectives of this project include:

- Establish a formal governance organization and the associated protocols needed to effectively manage projects across the Enterprise
- Secure executive level support and identify representatives from all entities within the PME to support the governance structure
- Clearly define roles and responsibilities of each governance level and communicate and mandate them throughout the Enterprise
- Initiate cultural change management training to reinforce the use of MITA and 7C&S
- Establish an ongoing Medicaid Enterprise data governance strategy that will improve the ability to compare data across DPW programs and other state agencies
- Continue to develop an Enterprise Systems Integration Strategy

- Continue to leverage the PME technical capabilities and infrastructure using a configuration tool (Configuration Management Data Base (CMDB))
- Formalize a plan to develop a conceptual Enterprise data model (CDM)
- Identify staffing needs to support the governance activities on an ongoing basis

Project Management Approach:
The services for this initiative may be outsourced through a competitive bid process or done with existing resources. With either approach, the project implementation will be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:
The budget is expected to cost less than $2 million over the 1-year period.

While there is not a direct one to one correlation between this transformation effort and the individual MITA business processes, the Enterprise will realize maturity gains through improved capabilities as a result of establishing the Enterprise governance structure. This lays the groundwork for future MITA capability enhancements and establishes standards that will directly increase many MITA capability levels.

6.3.2 Enterprise Content Management (ECM) Initiative

Duration:
The timeframe for this initiative is still To Be Determined (TBD).

Description:
Pennsylvania currently does not have a robust enterprise-wide content and workflow management system. Presently, hardcopy files, documents, and images are electronically routed throughout the Enterprise to the appropriate individuals through common repositories and email.

Pennsylvania continues to promote the use of the web as it moves forward towards an entirely paperless environment. An existing data management system, known as DocuShare, for unstructured data, is in place to support ECM for both the self-service member portal and ongoing case management components of the Commonwealth's Enterprise. This asset will continue to be enhanced and improved for use by the Enterprise.

For any remaining paper, the Enterprise plans to implement an Enterprise solution to scan, index, and manage hard copy documentation. The solution will provide for ongoing ECM and workflow management functionality. This project workflow management system can unlock the full potential of an ECM system, distributing information anywhere it is needed across the Enterprise.

Goals and Objectives:
The goal of this initiative will be to implement a single Enterprise ECM module to allow users to see all documents associated with a provider, client, contractor, or other entity. Functional objectives include:

- Expanded Workflow Management of Business Processes
- Document Scanning and Imaging

Project Management Approach:
This project will create and implement the initial workflow model in selected enterprise units, to be rolled out incrementally over time to the remainder of the Enterprise. Implementing these capabilities in this manner has the potential to decrease risks associated with:

- Implementing systems on a large scale
- Workflow stoppages due to resource availability

- Lengthened implementation and testing schedules

Commonwealth staff will oversee and participate in the project governance as detailed in Section 6.2.1, Project Management. They will also provide subject matter expertise and technical support as needed.

Project Budget:
Once the solution is determined, funding (TBD) will be requested to support the project goals.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 39: MITA Maturity Gains from ECM

Member Management	**Provider Management**
ME01 – Manage Member Information ME02 – Manage Applicant and Member Communication ME08 – Manage Member Grievance and Appeal	All Processes
Financial Management	**Performance Management**
FM05 – Manage Cost Settlement FM07 – Manage Accounts Receivable Collection/Refund FM08 – Prepare Member Invoice FM13 – Manage Accounts Payable Information FM15 – Manage 1099s	PE03 – Manage Compliance Incident Information PE04 – Investigate Adverse Action Incident
Operations Management	**Care Management**
OM04 – Apply Attachment OM05 – Apply Mass Adjustment OM14 – Generate Remittance Advice OM30 – Manage Drug Rebate Dispute Resolution	CM02 – Manage Case and Treatment Plan Information
Business Relationship Management	**Health Plan Management**
	All Processes
Contractor Management	**Eligibility and Enrollment Management**
CO01 – Manage Contractor Information CO02 – Manage Contractor Communication CO05 – Produce Solicitation	–

6.3.3 Enterprise Data Warehouse (EDW) Upgrade

Duration:
The timeframe for this initiative is still TBD.

Description:
The EDW facilitates the storage and querying of information across DPW's program offices and enhances the information and reporting delivery capability of data from the EDW to a technically diverse user population. Currently, the EDW spans multiple systems and programs, primarily within DPW, and provides the data, optimized for reporting and analysis.

Information from the EDW is provided to users in a variety of delivery methods including pre-defined reports, cubes, packages, dashboards, and maps. The EDW consists of a subject oriented, integrated, time-variant, collection of data in support of management's decision making process. The EDW database is structured to efficiently retrieve large volumes of data.

This initiative focuses on better data management and upgrading the EDW to provide more robust reporting capabilities, including ad hoc reporting and dashboards in support of the Reporting Condition. The EDW upgrade will implement an integrated health care database that will eventually incorporate data from across the PME, including agencies outside of DPW such as the PDA, Department of Insurance, and DOH.

The integrated health care database will make the data available from a citizen-centric view, eliminating the silos across program areas and agencies as it is today. This horizontal view will allow users to look across the Enterprise for more consistent data, better trending, and useful cause and effect analysis.

The Department plans to look at opportunities to query unstructured data through the use of new analytical tools. This data provides key information that is currently unavailable for queries and analysis, but that can be extremely valuable to users.

As part of the Enterprise Transition/Transformation Initiative, a Data Management Work Group will be established to manage and enforce the data governance strategy. This work group will strive to standardize data across all programs, between all contractors, and throughout the Enterprise, promoting stronger, more consistent data results.

Goals and Objectives:

The EDW upgrade will realize the following goals:

- Expand the EDW to include integrated data from across the PME
- Improve Enterprise reporting capabilities and reliability of the data to contribute to program evaluation, improvement in business operations, and transparency and accountability
- Create and mandate the use of well-defined data standards to manage the data across the Enterprise for consistent reporting

Project Management Approach:

Contractors perform DPW IT support and services for the EDW. Contractors will provide all of the resources required to complete the identified work. Commonwealth staff will oversee and participate in the project governance as detailed in Section 6.2.1, Project Management. They will also provide subject matter expertise and technical support as needed.

Project Budget:

As activities that are eligible for enhanced funding are identified, the APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 40: MITA Maturity Gains from the EDW Upgrade

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
FM05 – Cost Settlement FM16 – Formulate Budget FM19 – Generate Financial Report	PE01 – Identify Utilization Anomalies PE04 – Investigate Adverse Action Incident
Operations Management	**Care Management**
OM05 – Apply Mass Adjustment OM28 – Manage Data OM30 – Manage Drug Rebate Dispute Resolution	CM02 – Manage Case and Treatment Plan Information
Business Relationship Management	**Health Plan Management**
–	PL01 – Develop Agency Goals and Objectives PL02 – Maintain Program Policy PL04 – Manage Health Plan Information PL05 – Manage Performance Measures PL06 – Manage Health Benefit Information PL08 – Manage rate Setting
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.3.4 Care/Case Management

Duration:

The feasibility study will be completed in 2013. The timeframe for the remainder of the project will then be determined.

Description:

Studies show that beneficiaries that receive the proper health care services have better health outcomes and typically lower total cost of care. This initiative focuses on combining care/case management functionality that is currently supported through several systems and products into a common integrated module to improve business processes, leverage common capabilities, and provide better customer service – all objectives of the MITA framework and 7C&S.

The first step in this initiative is to; conduct a feasibility study to define the actual business needs, explore options for streamlining processes, and consolidate care/case management activities into a common module. The scope of work will be based on the results of the feasibility study and detailed in the APD.

Goals and Objectives:

The Commonwealth will implement a common care/case management module to meet the following goals:

- Consolidate care/case management functionality across as much of the Enterprise as possible, eliminating multiple separate and disparate systems
- Web-enable the care/case management functionality and provide a single portal for associated information and mobile access to this data
- Centralize web reporting to include all client data including managed care, FFS, waivers, and other programs for more robust reporting
- Realize faster completion times and lower costs to implement system changes and improvements

- Increase self-service and automation when feasible to improve access to care
- Be able to readily adapt to eHealth initiatives
- Integrate to the HIE to access and utilize EHR capabilities
- Develop the system as a separate module that could be accessed by the current and future MMIS systems

Project Management Approach:
DPW will utilize one of its IT services and support vendors to complete the initial care/case management assessment. The results will be provided to project governance teams for consideration.

Project Budget:
Once the feasibility study is completed, funding (TBD) will be requested to support the project goals.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 41: MITA Maturity Gains from the Care/Case Management Initiative

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
–	CM01 – Establish Case CM02 – Manage Case and Treatment Plan Information CM03 – Manage Population Health Outreach CM05 – Perform Screening and Assessment CM06 – Manage Treatment Plan and Outcomes CM08 – Authorize Service CM09 – Authorize Treatment Plan
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.3.5 Customer Relationship Management (CRM)

Duration:
Projected: August 2013 – December 2015

Description:
This initiative represents plans for a widely implemented strategy to manage the Commonwealth's interactions with providers, members, contractors, and other parties that interact with the Medicaid Enterprise. Today, manual processes and multiple systems are used for these interactions and little, if any, stakeholder satisfaction is tracked and measured. Through the use of technology and services, the Enterprise will centralize, organize, automate, and synchronize CRM business processes to modernize the customer service experience.

This project will start with managing and integrating provider communications with other similar resources across the Enterprise. The solution will support the auto-identification of callers and capturing

events, responses, dates, and other inputs/outputs. Options that provide the ability to submit interactions through the web and self service will be explored.

The types of cases managed will eventually expand to include member communications, contractor communication, grievance and appeals, and external stakeholder communication (i.e., state legislature, federal entities, and provider organizations).

Goals and Objectives:

This project will support better management of Enterprise interactions with external parties to make better decisions more quickly and provide the information to support accountability.

The Commonwealth will implement a system and services to meet the following objectives:

- Reduce the burden of manual management of Medicaid interactions through a comprehensive and automated solution
- Centralize CRM interaction information for improved, efficient interactions, and reportable data
- Make CRM interaction history available online to approved users
- Allow concurrent management of interactions across organizational and geographic boundaries
- Promote self-service through technology for more efficiency and to enhance customer service
- Deploy a modular system utilizing open interfaces

Project Management Approach:

The function will be outsourced through a competitive bid process unless it is determined that an existing system can be leveraged to support the Enterprise CRM needs. With either approach, the project implementation will be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:

Once the solution is determined, funding will be requested to support the project goals.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 42: MITA Maturity Gains from the CRM Enhancements

Member Management	Provider Management
ME02 – Manage Applicant and Member Communication ME08 – Manage Member Grievance and Appeal	PM01 – Manage Provider Information PM02 – Manage Provider Communication PM03 – Perform Provider Outreach PM07 – Manage Provider Grievance and Appeal PM08 – Terminate Provider
Financial Management	**Performance Management**
FM10 – Manage Member Premium Payment	PE01 – Identify Utilization Anomalies PE05 – Prepare REOMB
Operations Management	**Care Management**
–	–
Business Relationship Management	**Health Plan Management**
BR02 – Manage Business Relationship Communication	–
Contractor Management	**Eligibility and Enrollment Management**
CO02 – Manage Contractor Communication CO09 – Manage Contractor Grievance and Appeal	–

6.3.6 Pennsylvania Treasury Transformation Initiative

Duration:
In Progress: November 2012 – July 2014

Description:
The Pennsylvania Department of Treasury's IT systems manage about $15 billion in Commonwealth assets and processes about 48.7 million payments totaling $78.2 billion annually to numerous entities, including Medicaid providers, consumers, and business partners.

The Pennsylvania Treasury Transformation Initiative will streamline the Treasury Department's core financial and treasury management processes through business process re-engineering in conjunction with the implementation of best practices and new technologies. This Commonwealth Enterprise project will result in system and business process changes that will enhance the financial capabilities within the Medicaid Enterprise. For example, access to payment details will be available real-time and ad hoc reporting will allow analytic procedures to be applied to payment data. This transformation will produce a more robust bank reconciliation and facilitate providing payment information business partners.

The Treasury Project Team plans to adopt PeopleSoft™ Financial modules, features, and functions that add value to current practices and plan to minimize complexity by adopting only those modules, features, and functions that provide tangible benefits to Treasury and end users. They will ensure that accounting information is complete and traceable to tangible business events.

This project will focus on the Medicaid Enterprise changes needed for the Commonwealth Enterprise efforts. The Enterprise will look to utilize new functionality that will be available for business partners supporting the Business Results Condition and improving the level of maturity in the Financial Management business processes.

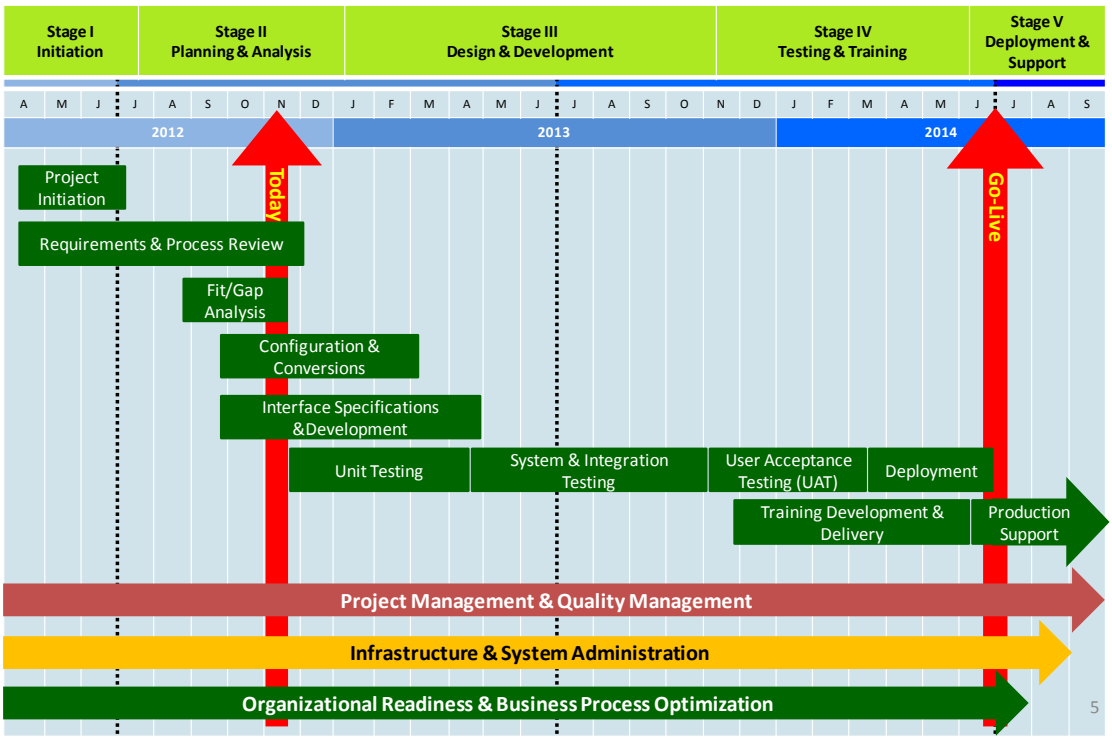
Goals and Objectives:
The following are the high level objectives for the Pennsylvania Department of Treasury Transformation Initiative that will benefit the Medicaid Enterprise:

- Streamline Treasury's core financial management processes through Business Process Optimization (BPO) and implementing best practices
- Eliminate the use of disparate, siloed systems such as the TABS system to complete the payment processes
- Standardize Treasury interfaces across Pennsylvania state agencies
- Improve operational effectiveness and increase staff productivity
- Eliminate administrative activities that do not add value, such as redundant keying and reconciliation of disparate systems
- Improve quality and accessibility of information for decision making

Project Management Approach:
Treasury is evaluating and modifying current business processes to enable an efficient implementation and adoption of best practices. Change agents from all agencies, including the Medicaid Enterprise, are involved and will prepare individuals and organizations with the skills and processes for successful implementation of all system and process changes.

The current Commonwealth Treasury Department's project timeline is provided in the figure below. This schedule directly affects the implementation date of the EFT and ERA standards and operating rules.

Figure 20: Pennsylvania Treasury Transformation Project Timeline



Project Budget:

As activities that are eligible for enhanced funding are identified, the APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 43: MITA Maturity Gains from the Treasury Transformation

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
FM06 – Manage Accounts Receivable Information FM07 – Manage Accounts Receivable Collection/Refund FM08 – Prepare Member Premium Invoice FM09 – Manage Invoice Payment FM10 – Manage Member Premium Payment FM11 – Manage Capitation Payment FM12 – Manage Incentive Payments FM13 – Manage Accounts Payable Information FM14 – Manage Accounts Payable Disbursement FM15 – Manage 1099s FM18 – Manage Fund FM19 – Generate Financial Report	–
Operations Management	**Care Management**
OM27 – Prepare Provider Payment	–
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.3.7 Commonwealth Data Center Computing Modernization Initiative

Duration:
The timeframe for this initiative is still TBD.

Description:
Currently, the Commonwealth datacenter resources are decentralized, and owned and operated under multiple datacenter service catalogs, processes, and procedures. This presents the Commonwealth with barriers to establishing interoperability between datacenters, implementing standard processes and procedures for datacenter oversight, and ensuring compliance with the same standards for datacenter operations.

To resolve these issues, Pennsylvania is undertaking a computing modernization initiative. This initiative includes implementing a new computing services model for all state agencies that provide a managed service approach to various infrastructures/computing platforms to service the needs of the Commonwealth in a secure, flexible, and on demand manner.

Proposals for this significant modernization initiative were due to the Commonwealth on June 16, 2013. Once the evaluation process has concluded, the award is made, and contract negotiations are completed, the PME will leverage this modernized computing approach to better align with the MITA framework and 7C&S. This initiative will be the effort required to transition the Medicaid Enterprise to this computing model.

Goals and Objectives:

The Commonwealth Enterprise Datacenter Modernization Initiative aligns with the MITA framework and is expected to achieve the following objectives for the Medicaid Enterprise:

- Provide a reliable, flexible, secure, and robust IT infrastructure to support the transformation to an information-focused organization
- Provide engineering support that will anticipate changes in business and technical requirements and make recommendations for staying current with industry best practices
- Establish the capability to support high-availability hosting, backup, and disaster recovery (DR) services to maintain continuity of government operations
- Ensure that the new datacenters adhere to the Commonwealth's contractual, regulatory, and policy compliance requirements for security, architecture, and SDLC standards
- Provide multiple environments and instances to support the enterprise application portfolio. For example: Development, Integration, System Acceptance Testing (SAT)/Universal Acceptance Testing (UAT), Training, load Testing, Pre-Production and Production.

Project Management Approach:

The Commonwealth OIT leads this initiative. The Commonwealth's EPMM will be used to manage overall project development and ensure the project meets business and technical standards.

Project Budget:

Once the award has been made and the project details are available, funding (TBD) will be requested to support the project goals.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 44: MITA Maturity Gains from the Data Center Computing Modernization

Member Management	Provider Management
ME01 – Manage Member Information	PM01 – Manage Provider Information PM08 – Terminate Provider
Financial Management	**Performance Management**
FM01 – Manage Provider Recoupment FM02 – Manage TPL Recovery FM03 – Manage Estate Recovery FM05 – Manage Cost Settlement FM06 – Manage Accounts Receivable Information FM08 – Prepare Member Invoice	PE01 – Identify Utilization Anomalies PE02 – Establish Compliance Incident PE03 – Manage Compliance Incident Information PE04 – Investigate Adverse Action Incident
Operations Management	**Care Management**
OM07 – Process Claim OM18 – Inquire Payment Status OM29 – Process Encounter	All Processes
Business Relationship Management	**Health Plan Management**
All Processes	PL05 – Manage Performance Measures
Contractor Management	**Eligibility and Enrollment Management**
All Processes	All Processes

6.3.8 Process Improvements Due to Changes in Business Models

Duration:
The timeframes for these enhancements are still TBD.

Description:
The Commonwealth recently moved the majority of its Medicaid population into mandatory managed care. With the implementation of statewide managed care and other changes in business models, the Enterprise recognizes that there are opportunities for process improvement and workflow efficiencies that will improve business process maturity ratings and support 7C&S.

This initiative will identify areas for improvement and the associated effort. Requests for funding will be submitted periodically based on the size of the project, scope, and timeframe. One example of the types of enhancement that are being considered is automating the entry of the capitation rates. Currently, this is a manual, and time consuming process that prevents the Enterprise from more than a maturity rating of 1 for the FM11– Manage Capitation Payment process.

Another example is developing enhanced monitoring of the Managed Care Organization systems, including claims adjudication and program integrity effectiveness. Another is identifying efficiencies to increase TPL recovery dollars.

Automation of processes aligns with the Business Results Condition, will improve workflow efficiency and accuracy, and improve the Maturity Levels of business processes.

Goals and Objectives:
This initiative is expected to achieve the following objectives for the Medicaid Enterprise:

- Identify process improvement opportunities and implement system enhancements to support the recent and future changes to business models
- Increase MITA maturity ratings in the Member Management, Business Relationship Management, Contractor Management, Financial Management, and Care Management business areas through the automation of manual processes
- Improve stakeholder satisfaction

Project Management Approach:
All system changes related to these process improvements will be managed in accordance with established procedures under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:
As activities that are eligible for enhanced funding are identified, the APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 45: MITA Maturity Gains from Process Improvements Due to Changes in Business Models

Member Management	Provider Management
ME01 – Manage Member Information ME02 – Manage Applicant and Member Communication ME03 – Perform Population and Member Outreach ME08 – Manage Member Grievance and Appeal	–
Financial Management	**Performance Management**
FM02 – Manage TPL Recovery FM11 – Manage Capitation Payment	–
Operations Management	**Care Management**
OM07 – Process Claim OM29 – Process Encounter	CM01 – Establish Case CM02 – Manage Case and Treatment Plan CM06 – Manage Treatment Plan and Outcomes
Business Relationship Management	**Health Plan Management**
BR01 – Establish Business Relationship BR02 – Manage Business Relationship Communication BR03 – Manage Business Relationship Information BR04 – Terminate Business Relationship	PL05 – Manage Performance Measures
Contractor Management	**Eligibility and Enrollment Management**
CO07 – Manage Contract	EE02 – Enroll Member EE04 – Inquire Member Eligibility

6.3.9 Appeals Management Module

Duration:
Projected: July 2013 – December 2015

Description:
The Department's BHA has a standalone system that requires data entry of all appeals received by the Bureau, with updates being made throughout the life of the appeal. The current process is time consuming, inefficient, not user friendly and uses antiquated technology that will no longer be supported in the long term. The current system does not take advantage of capabilities offered by newer technologies, such as document imaging or electronic processing, and does not integrate with the Department's other existing systems. As a result, BHA has difficulty offering adequate customer service both internally and externally throughout the hearing and appeal process.

The existing system offers limited management reporting and is based on outdated business rules that are adjusted due to changes in laws and regulations. This creates a challenge in managing the day to day operations and in meeting the mandate to provide fair and impartial hearings to indivdiuals served.

This project will provide a new solution for this important business process to include:

- An Internet accessible website that can be used by appellants (i.e., recipients, non-recipients, providers, community partners) and the CAOs to submit appeals, upload appeal related documents, submit withdrawals and check status
- A document imaging repository that promotes paperless appeal document filing, provides document imaging capabilities, supports search and view functionality, and leverages existing CIS imaging for CAO scanned documents

- A means for the CAOs to data enter recipient appeal information into the appeal database by leveraging data available from the eligibility system (CIS)
- An Appeal Workload Dashboard and processing workflow that offers automatic generation and assignment of work activities (i.e., tasks) based on a defined set of work assignment rules in a dashboard format
- An appeal narrative component that allows general comments related to the appeal to be captured and maintained
- A manual and automated scheduling functionality for face-to-face hearings, telephone hearings, and pre-hearing conferences
- Flexible and dynamic correspondence templates that can be generated manually or automatically
- A management dashboard and reports to include business operations metrics, standard, defined operational reports
- The capability to move a defined set of data and documents from the old appeals tracking application(s) to the new application, plus archiving and data retrieval of aging appeal data
- The ability to define and maintain business rules and/or system reference tables used for automated and manual appeals processing

Goals and Objectives:

The goal of this initiative is to implement a cost effective and reliable Enterprise wide solution to support core business operations in order to:

- Retire legacy systems supporting the appeals process that have passed their useful life and functional capabilities
- Secure, consolidate, and centralize data repositories and reporting to provide a more complete management reporting function
- Streamline business systems processes and governance
- Facilitate compliance with federally mandated timeframes for the administrative hearing process
- Improve efficiency and accuracy of processing almost 80,000 appeals annually
- Improve efficiency and accuracy in scheduling and tracking approximately 45,000 hearings conducted annually statewide
- Reduce hard copy documents, photocopying, storage and mailing costs
- Improve customer service
- Leverage and integrate existing Enterprise systems

Project Management Approach:

The Appeals Management module will be outsourced through a competitive bid process unless it is determined that an existing system can be leveraged to support the Enterprise appeal needs. With either approach, the project implementation will be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:

When a solution for this project is defined, the APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 46: MITA Maturity Gains from the Appeals Management Module

Member Management	**Provider Management**
ME08 – Manage Member Grievance and Appeal	PM07 – Manage Provider Grievance and Appeal
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
OM30 – Manage Drug Rebate Dispute Resolution	–
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
CO09 – Manage Contractor Grievance and Appeal	–

6.3.10 Enablement of Mobile Technology

Duration:
The timeframe for these enhancements are still TBD.

Description:
Studies show that mobile Internet usage is growing faster than desktop Internet usage. By 2014, mobile technology is expected to be the most common way of accessing the Internet. Mobile technologies have immense potential as tools to promote healthy behavioral change, to transform the caregiver–patient relationship, and to revolutionize the way healthcare is delivered.

For this project, the Enterprise will evaluate how it can use mobile technology to enhance access to data and promote self-management. Existing Enterprise solutions will be evaluated and as new projects are identified and defined, consideration will be given to supporting the use of mobile enablement as a presentation layer.

As stated in the Modularity Standard of 7C&S, the system architecture should utilize a UI framework that deploys presentation components to allow for communication with disparate populations using different media formats such as web, email, mobile, and short message service (i.e., text messaging). Further, the Business Results Condition stresses that the 21st-century customer experience should include the ability to submit and manage interactions with Medicaid through the web and to self-manage and monitor accounts and history electronically and accommodate customer preferences for communications by email, text, mobile devices, or phones. This initiative will support both of these conditions.

Goals and Objectives:
This project will accomplish the following goals and objectives:

- Enhance the customer experience through the use of mobile enablement, promoting self-management, and allowing consumers to more easily engage in their healthcare
- Provide Commonwealth users with access to data via mobile technology
- Support provider data needs through the use of mobile technology for patient care

Project Management Approach:
All system changes related to these process improvements will be managed in accordance with established procedures under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Projected Budget:
As activities that are eligible for enhanced funding are identified, the APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 47: MITA Maturity Gains from the Use of Mobile Technology

Member Management	Provider Management
ME02 – Manage Applicant and Member Communication	PM02 – Manage Provider Communication
Financial Management	**Performance Management**
–	PE01 – Identify Utilization Anomalies
Operations Management	**Care Management**
OM18 – Inquire Payment Status	CM02 – Manage Case and Treatment Plan Information CM03 – Manage Population Health Outreach CM06 – Manage Treatment Plan and Outcomes
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	EE08 – Inquire Provider Information

6.4 Patient Protection and Affordable Care Act (PPACA)

The next three projects are directly related to the PPACA and the associated changes necessary for compliance. Each of the projects included in this subsection addresses the timeframe, goals and objectives, project management approach, and the proposed budget for the project being described. At the end of each section, a table identifies the key MITA business processes that are impacted by the project.

6.4.1 Provider Screening and Enrollment

Duration:
In Progress: March 1, 2013 – March 31, 2014 for the initial two phases

Dates for subsequent activities: TBD.

Description:
The Commonwealth of Pennsylvania provider management model encompasses various program offices that perform or have a role in performing provider enrollment activities. The program offices follow work management processes, and utilize the MMIS that interfaces with the MPI. System changes are needed to fulfill the federally mandated requirements of the PPACA for Provider Screening and Enrollment.

This Provider Screening and Enrollment project will be done in multiple phases. An APD for the initial two phases of this initiative was submitted and approved earlier this year and the associated activities are underway.

The first phase implements enhancements needed from an infrastructure perspective to establish systems and processes to support data requirements. The implementation activities primarily involve the creation of new fields within the MMIS to capture and store data elements required for provider enrollment screening. This phase also creates new auditing features, establishes automated re-enrollment/revalidation

messages and alerts, and enhances existing functionality within the Internet application and MMIS windows.

The second phase focuses on planning activities to identify the additional modifications needed for certain provider related activities and to evaluate overall workflow management processes. As part of the planning sessions, consideration is being given to how the enrollment process needs to change and what can be consolidated in the future. It is the Department's goal to use this planning initiative to make the prescreening activities modular or done as services so that the functionality can be reused with a replacement MMIS and throughout the Enterprise, supporting the Modularity Standard.

The planning activities will also examine updating initial enrollment verifications to become more automated, to promote self-service through the use of the web for communicating and accessing information, and to accommodate specified screening requirements prior to enrollment in the Medicaid program. All provider enrollment processes, workflow, and systems will be evaluated, including those enrollments that are started in interfacing systems such as the HCSIS.

To increase the degree of automation in the screening process and support the Industry Standards and Business Results Conditions, this will be done through an expansion of the EDX to include real-time provider data interfaces whenever feasible. The Department is looking for guidance and participation from CMS in order to systematically automate federal database checks that are currently not available, but required. This also includes processing and reporting additional file exchanges between the MMIS and other entities as set forth by the final rule.

Upon completion of the planning activities, an APD will be submitted detailing the next phases and funding requests for this initiative.

Goals and Objectives:

The long term goals and objectives of this project include:

- Consolidate provider enrollment functions across the Enterprise where ever possible to eliminate redundancy and improve efficiency
- Develop or procure an enhanced PR designed to expand and provide web-enabled access for all relevant stakeholders to support data needs
- Develop a centralized provider enrollment, credentialing, and re-enrollment/revalidation process that is integrated with web-enabled applications
- Implement a prescreening module that supports reusability
- Enhance business process automation so that once information is received via integrated data sources, the information is available for viewing, posting, analysis, and tracking
- Improve provider notification by utilizing electronic communication media, standard messages, and national standards in the process
- Expand the EDX to include real-time provider interfaces, including the NPPES to validate provider enrollment information
- Improve the efficiency and accuracy of the enrollment process by utilizing automated data collection and validation processes with external interfaces

Project Management Approach:

Project management activities will be conducted to address partial or full implementation and planning for all of the requirements including design, development, testing, installation, reporting, and review. Commonwealth staff will oversee and participate in the project governance as detailed in Section 6.2.1, Project Management. They will monitor the project to ensure that the multiple implementation targets are met, and that overlapping projects are completed in tandem in consideration of all Enterprise needs.

A Project Management Team has been selected to lead and oversee the implementation of the Provider Screening and Enrollment functions. The team is comprised of representatives from 11 bureaus within the Department, and key personnel from the MMIS and HCSIS vendors.

Project Budget:
CMS has approved $1.358 million for the initial one year APD request. Once planning activities are finalized, additional funding (TBD) will be requested to support the project goals.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 48: MITA Maturity Gains from the Provider Screening and Enrollment Requirements

Member Management	Provider Management
–	PM01 – Manage Provider Information PM02 – Manage Provider Communication PM08 – Terminate Provider
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
–	–
Business Relationship Management	**Health Plan Management**
BR01 – Establish Business Relationship BR02 – Manage Business Relationship Communication BR03 – Manage Business Relationship Information BR04 – Terminate Business Relationship	–
Contractor Management	**Eligibility and Enrollment Management**
–	EE05 – Determine Provider Eligibility EE06 – Enroll Provider EE07 – Disenroll Provider EE08 – Inquire Provider Information

6.4.2 Member Eligibility and Enrollment

Duration:
In Progress: March 2013 – December 2015

Description:
Pennsylvania's existing integrated eligibility system is being updated as part of this project to support the implementation of the PPACA mandates and the administration of Medicaid and its other federally funded public assistance programs in a phased approach. Pennsylvania has decided not to pursue a state-based HIX at this time and will interface with the FFM. The systems changes needed to fulfill the federally mandated requirements and to ensure alignment of its eligibility-related systems with the MITA framework and 7C&S were outlined in an IAPD submitted and approved by CMS earlier this year.

DPW has been upgrading its CIS in incremental phases over the past several years. Modifications have included moving segments from a mainframe environment to an open systems environment, introducing a Corticon rules-based engine, and streamlining functionality, among other things.

This project encompasses four additional incremental phases that will be implemented over the next 2 ½-years to meet the requirements of PPACA and 7C&S. The key aspects of each phase are described below:

PPACA Phase 1 focuses on developing an architecture and conceptual design for EDXs that will serve as a new framework for any new or existing interfaces.

PPACA Phase 2 includes system changes required to comply with the PPACA, including Modified Adjusted Gross Income (MAGI) methodologies for determining eligibility for Medicaid. Additionally, this phase includes system changes required for integration with the FFM.

PPACA Phase 3 focuses on expanding the EDX, as well as the expansion of automated case actions using real-time information and further increasing accessibility to the self service system, COMPASS.

PPACA Phase 4 targets the migration of the complex eligibility determination rules from the procedural mainframe code into the robust Corticon Business Rules Engine for non-MAGI Medicaid, LTC, Cash, SNAP, and LIHEAP. This release further expands the number of real-time data sources available through the EDX.

With the implementation of final phase of the PPACA project in October of 2015, Pennsylvania envisions the integrated eligibility system to make determinations of both CHIP and MA eligibility.

As part of this project, DPW will work with DOH to evaluate capabilities to share, or re-use system components that were developed to implement the ACA. States are able to leverage ACA investments across multiple program areas (including WIC) without cost allocation requirements provided certain guidelines are followed and the goods and services are incurred prior to December 31, 2015. This information was shared with the Commonwealth in a letter dated May 21, 2013 from CMS and the USDA.

Pennsylvania's vision for the future eligibility environment will involve a consumer accessing information and checking their eligibility for all human services benefits, primarily through an online portal that provides robust self-service tools; a rules engine providing real-time determination results; all of which feeds a modern, modular eligibility system that stores the record and performs other needed functionality.

Goals and Objectives:

The goals of this project include:

- Improve Pennsylvania's eligibility processing capabilities and enhance the current eligibility system in a controlled, deliberate manner that mitigates impacts to the Commonwealth's business and program operations
- Realize CMS compliance with the new 7C&S and the PPACA
- Enable more consumer self-service activities by adopting mobile technology capabilities for the delivery and receipt of content, as well as interactive voice response (IVR) technology and electronic notification processes that begin to change how consumers are engaged
- Continue to expand the Department's EDX to provide more real-time interfaces of critical data that will streamline eligibility and improve program integrity
- Complete system changes required for integration with the FFM
- Integrate CHIP eligibility data into the CIS to support the Interoperability Condition

Project Management Approach:

DPW will leverage existing contracts with several vendors for IT Services and Support for this project. All system changes related to this project will be managed in accordance with established procedures under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:
This project is funded under the ACA Eligibility & Enrollment Systems Changes IAPD approved by CMS earlier this year.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 49: MITA Maturity Gains from the Member Eligibility and Enrollment Enhancements

Member Management	Provider Management
ME01 – Manage Member Information ME02 – Manage Applicant and Member Communication ME03 – Perform Population and Member Outreach ME08 – Manage Member Grievance and Appeal	–
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
–	–
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	EE01 – Determine Member Eligibility EE02 – Enroll Member EE03 – Disenroll Member EE04 – Inquire Member Eligibility

6.4.3 Fraud Waste and Abuse (FWA) Initiatives

Duration:
In Progress: May 2012 — December 2015

Description:
The Commonwealth continues to focus on implementing enhanced functionality to support the identification and prevention of provider and member FWA. The Department started several program integrity initiatives last year and has integrated them into the PME.

Provider FWA

The first phase integrated the McKesson InvestiClaim™ FWA module into the MMIS in January 2013. This added business rules to the MMIS to detect aberrant claims billing patterns and identify potential fraud during claims and managed care encounter processing, prior to payment. The second phase incorporated the McKesson/FICO FWA analytics and was completed the end of May 2013. This recent functionality will further improve monitoring and identify provider FWA through comprehensive analytics and scoring.

The Department plans to further enhance its capabilities to identify potential program integrity issues based on encounter data.

Member FWA

Modifications are being made to the DPW integrated eligibility system in phases to support enhanced fraud, waste and abuse detection. These enhancements are being done in concert with PPACA changes to

advance the Department's objective of increasing program integrity through more real-time interfaces and automated case actions.

The first phase, completed in April 2013, focused on developing an architecture and conceptual design for the EDX, which will serve as a new framework for any new or existing interfaces. The EDX establishes an integrated model for sharing information across the organization. The EDX model replaces the traditional point-to-point interfaces model and provides a more SOA-based real-time exchange of information that will be leveraged as the state looks to integrate with the FFM and the Federal Data Services Hub.

Subsequent phases will include system changes required for the integration with the FFM. This integration will result in additional FWA prevention measures and automated case actions supporting FWA monitoring and prevention.

These efforts will allow the Department to integrate with other modules across the Enterprise and identify possible fraud and abuse cases.

Goals and Objectives:

The Commonwealth seeks to meet the following objectives as part of this project:

- Identify abusers, both providers and members
- Implement FWA measures and monitor results
- Reduce program costs over time
- Recover funds and prosecute offenders
- Prevent future FWA.
- Increase automation to improve the accuracy and efficiency of the process

Project Management Approach:

Contractors perform DPW IT support and services, and MMIS enhancements. The contractors will provide the resources required to complete the identified work. Commonwealth staff will oversee and participate in the project governance as detailed in Section 6.2.1, Project Management. They will also provide subject matter expertise and technical support as needed.

Project Budget:

The IAPD for InvestiClaim, dated April 3, 2012 was approved by CMS on April 17, 2012. As additional program integrity activities that are eligible for enhanced funding are identified, the APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 50: MITA Maturity Gains from the FWA Initiatives

Member Management	Provider Management
–	PM08 – Terminate Provider
Financial Management	**Performance Management**
–	PE01 – Identify Utilization Anomalies PE02 – Establish Compliance Incident PE03 – Manage Compliance Incident Information PE04 – Investigate Adverse Action Incident PE05 – Prepare REOMB
Operations Management	**Care Management**
–	–

Business Relationship Management	Health Plan Management
BR04 – Terminate Business Relationship	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.5 Health Information Technology for Clinical Health (HITECH)

The projects in this next section are related to the HITECH Act. The projected timeframe, goals and objectives, management approach, and the proposed budget are included for each project. At the end of each subsection, a table identifies the key MITA business processes that are impacted by the project.

6.5.1 State Medicaid HIT Plan

Duration:
In Progress: June 2011 – February 2021

Description:
The SMHP describes the activities an SMA will engage in over the next 5-years relative to implementing the Medicaid provisions of Section 4201 of ARRA. The Pennsylvania SMHP is an evolving document and will be updated regularly to reflect the program's status and communicate planned activities to CMS.

Goals and Objectives:
The Department's Medical Assistance Health Information Technology (MAHIT) Vision is to improve the quality and coordination of care by connecting providers to patient information at the point of care through the meaningful use of EHRs. The Department's HIT goals include:

- Enable providers and consumers to understand the benefits of HIT adoption and the importance of exchanging health information for patients and caregivers through increased awareness and education
- Provide better information to support clinical decisions by providers, reducing costs and increasing the probability of quality outcomes when combined with best practices and a common approach for consumers
- Eliminate duplicative services and administrative inefficiencies for better care coordination for consumers and to decrease the overall cost of care while improving positive outcomes
- Provide opportunities to enhance and improve current quality initiatives for both providers and consumers and allow the Department to assess the effectiveness of existing programs and identify gaps in care with data capture and analysis

Project Management Approach:
The SMHP is updated regularly as needed and/or as required by CMS. The Department is taking part in all planning and development activities for HIE and other HIT activities. MAHIT initiative team members participate in the various HIT workgroups at both the national and state level.

Project Budget:
The funding has been secured though December 2014 via the Pennsylvania approved HIT IAPD. Updated requests will be submitted as required.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 51: MITA Maturity Gains from the SMHP

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
FM12 – Manage Incentive Payments	–
Operations Management	**Care Management**
–	–
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.5.2 Statewide Health Information Exchange (HIE) and Commonwealth Internal HIE (CI-HIE)

Duration:
In Progress: June 2013 and will be ongoing.

Description:
In July 2012, legislation was approved to create the Pennsylvania eHealth Partnership Authority (Authority) to improve health care delivery and health care outcomes in Pennsylvania by enabling the secure exchange of health information. The Authority took over the work of its predecessor, the Pennsylvania eHealth Collaborative, which began by providing leadership and strategic direction for public and private, federally funded and state-funded investments in HIT initiatives, including HIE capabilities and other related HIT efforts.

Pennsylvania was awarded $17.1 million under HITECH to help establish an HIE that provides a CSS layer. The CSS is the key component that will enable the secure, confidential electronic exchange of medical records between state-certified organizations—HIEs and Health Information Service Providers (HISPs). The CSS layer will also provide access to services such as:

- Provider Directory services to locate providers across Pennsylvania
- Patient Index services to uniquely identify a patient throughout the State
- Record Locator services to locate sources of patient records
- An Opt-Out Registry to record patient consent selections

The Medicaid Enterprise is working with the Authority and other regional HIE organizations in Pennsylvania to promote the exchange of health information among medical providers and with the Commonwealth via the implementation of the CI-HIE. The Enterprise envisions that in 5-years HIEs will be used to transport Clinical Quality Measures (CQMs) to allow the DPW to analyze the impact of HIT on health outcomes and medical costs for MA and other programs. The Enterprise also envisions that the HIE can be used to simplify some of its internal operations, e.g., accessing medical record information for Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, claims processing medical record review, and providing additional information for complex case management.

For meaningful use, the Enterprise envisions that it will leverage the statewide network to potentially receive electronic CQMs associated with meaningful use requirements. These CQMs will be placed into a data repository (refer to section 6.5.4) for health outcome analysis. When possible, the Enterprise will also look to merge clinical data with administrative data (claims, PA, and case management data) for cost analysis.

MA is also supporting the implementation of regional HIEs with high Medicaid patient populations (i.e., Southeastern Pennsylvania HIEs). Additionally, MA is considering supporting the funding for the onboarding of providers that have qualified for EHR incentive payments to transfer data via regional HIEs.

Goals and Objectives:

The PME looks to achieve the following goals to create a CI-HIE capability in Pennsylvania:

- Support a statewide approach that is aligned with the Federal HIT Strategic Plan, including the adoption of and adherence to federally-recognized standards
- Facilitate the ability to exchange health care information using the specifications adopted for NwHIN, beginning with the implementation of Depression Information Resource & Education Centre (DIRECT) specifications
- Strengthen the continuity and coordination of care through enhanced data exchange to help transform health care delivery to a quality patient-centered model
- Support meaningful use of HIT by eligible professionals and hospitals
- Provide authorized Commonwealth users secure access to patient information submitted by the provider
- Lower health care costs by reducing duplication of testing and services
- Ensure that the CI-HIE initiative is guided by an integrated governance structure of key stakeholders

Project Management Approach:

The Enterprise will continue to pursue the infrastructure (i.e., hardware and software), resources (i.e., staff and funding), and agreements (i.e., legal, data sharing, and privacy) necessary to participate in the internal HIE and to utilize the CSS layer, leveraging this functionality as part of the Enterprise's HIT and HIE vision.

By following the various HIT initiatives across the Commonwealth, the Enterprise will be able to capitalize on existing structures to reduce duplication efforts.

Project Budget:

The CI-HIE funding will be determined once the Statewide HIE efforts are underway. The APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 52: MITA Maturity Gains from the Statewide HIE and CI-HIE

Member Management	Provider Management
ME01 – Manage Member Information	–
Financial Management	**Performance Management**
FM02 – Manage TPL Recovery	PE01 – Identify Utilization Anomalies PE04 – Investigate Adverse Action Incident
Operations Management	**Care Management**
OM04 – Apply Attachment OM07 – Process Claim OM29 – Process Encounter	CM01 – Establish Case CM02 – Manage Case and Treatment Plan Information CM03 – Manage Population Health Outreach CM04 – Manage Registry CM05 – Perform Screening and Assessment CM06 – Manage Treatment Plan and Outcomes CM08 – Authorize Service CM09 – Authorize Treatment Plan
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.5.3 EHR Incentive Program Payments/MAPIR/Meaningful Use

Duration:
In Progress: June 2011 – February 2021

Description:
HITECH provides Medicare and Medicaid incentives to eligible providers to encourage the adoption and meaningful use of certified EHR systems. The Medicaid EHR Incentive Program provides the payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. Regular reporting to CMS is required for provider eligibility, patient volume, payments, attestations, and meaningful use demonstration.

Incentive payments are available to eligible providers as they adopt technology in their first year of participation and continue to demonstrate meaningful use for up to five additional participation years. The Medicaid EHR Incentive Program began in Pennsylvania on June 6, 2011. Pennsylvania has made more than $210 million in incentive payments to eligible providers since that time.

Pennsylvania was, and continues to be a leader in the MAPIR multi-state collaborative. Using open source products, the 13-state MAPIR Collaborative designed and implemented a module that is used to capture provider R&A information at the state level, as well as interface with the CMS R&A system and ONC for HIT, and support meaningful use requirements. This module promotes the Modularity Standard as it contains web services between individual state's provider portal and the MAPIR module. It also contains a standardized interface to each individual state's MMIS for EHR incentive payments purposes.

The EHR Incentive Program requires providers to show that they are "meaningfully using" their EHRs by meeting thresholds for a number of objectives established by CMS. All providers begin participating by meeting the Stage 1 requirements for a 90-day period in their first year of meaningful use and a full year in their second year of meaningful use. After meeting the Stage 1 requirements, providers have to then

meet Stage 2 requirements for two full years. These distinctive requirements result in ongoing changes and enhancements to the MAPIR application over the course of the program.

In support of the Leverage Condition, the cost of developing the MAPIR application was, and continues to be, shared across collaborating states, significantly reducing the cost that each state would spend to implement a system for this program. Ongoing software releases are issued and applied to the MAPIR application to align with the program requirements and CMS and ONC system enhancements. Provider education and program support activities are also required.

For this Roadmap initiative, enhanced funding requests will continue to be submitted through state specific APDs and joint MAPIR Collaborative APDs as appropriate.

Goals and Objectives:

The PME expects to achieve the following goals related to the EHR Incentive Program, MAPIR, and meaningful use:

- Maintain ongoing federal compliance with the EHR Incentive Program and advanced stages of meaningful use
- Increase provider participation in the EHR Incentive Program
- Verify provider attestations through MAPIR and ensure that providers meet CMS' meaningful use criteria
- Support EHR Incentive Program provider needs and education
- Be a leader in the use of electronic health care information to improve the quality and cost-effectiveness of service delivery for MA consumers
- Continue to play a leadership role in the MAPIR Collaborative, supporting the goals of the MITA framework and 7C&S

Project Management Approach:

For MAPIR related activities, the established MAPIR governance structure comprised of representatives from each participating state is used. This governance structure guides the ongoing development and deployment of the MAPIR application and ensures the core design meets the requirements necessary to facilitate incentive payments to providers in accordance with the provisions outlined in HITECH.

Other related activities will continue to be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:

The funding has been secured though December 2014 via the Pennsylvania approved HIT IAPD.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 53: MITA Maturity Gains from the EHR Incentive Program and Meaningful Use

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
FM12 – Manage Incentive Payments	–
Operations Management	**Care Management**
–	–
Business Relationship Management	**Health Plan Management**
–	PL05 – Manage Performance Measures
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.5.4 Pennsylvania Clinical Quality Measures (CQMs) Repository

Duration:
July 2013 – September 2014

Description:
This project is an extension of the ongoing EHR Incentive Program and will implement a data repository to store patient level CQM data. According to CMS, CQMs assess "the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient in an optimal timeframe."

CQMs measure many aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagements, population and public health, and clinical guidelines. This data will be a valuable resource to the Enterprise for program and policy planning and evaluation.

This data repository will eventually leverage the state HIE and CI-HIE to receive the data. It will utilize an analytical tool to evaluate health outcomes and perform clinical analysis. When feasible, the Enterprise will also look to merge clinical data with administrative data (claims, PA, and case management data) for cost analysis.

Goals and Objectives:
The Enterprise seeks to meet the following objectives as part of this project:

- Collect meaningful use clinical data to analyze and identify opportunities for quality improvement interventions
- Supply feedback to providers to help them continue to evolve in the meaningful use of the EHR systems
- Assess quality improvements using the meaningful use data and evaluate changes in utilization and service patterns in relation to meaningful use stages
- Improve provider performance on clinical quality measures by developing metrics and tracking mechanisms for meaningful use reporting
- Identify areas for quality improvement
- Identify differences in care/outcomes among various populations
- Provide CQM data to the MA MCOs to analyze health outcomes and improve care coordination between providers

Project Management Approach:
The services for this initiative may be outsourced through a competitive bid process or done with existing resources. With either approach, the project implementation will be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:
Once the solution is finalized, funding (TBD) will be requested to support the project goals.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 54: MITA Maturity Gains from the CQM Repository

Member Management	**Provider Management**
–	–
Financial Management	**Performance Management**
FM12 – Manage Incentive Payments	PE01 – Identify Utilization Anomalies
Operations Management	**Care Management**
–	CM03 – Manage Population Health Outreach CM06 – Manage Treatment Plan and Outcomes CM09 – Authorize Treatment Plan
Business Relationship Management	**Health Plan Management**
–	PL01 – Develop Agency Goals and Objectives PL04 – Manage Health Plan Information PL05 – Manage Performance Measures
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.6 MMIS Planning and Procurement Support

This next section reflects two projects that focus on the MMIS procurement process. Each project includes the projected timeframe, goals and objectives, project management approach, and the proposed budget for the project being described. At the end of each subsection, a table identifies the key MITA business processes that are impacted by the project.

6.6.1 MMIS Procurement Planning Activities

Duration:
Projected: July 2013 – October 2014

Description:
Many states use the replacement of their MMIS as a catalyst for significant change in business processes and a strategy for improving the MMLs. Pennsylvania implemented its MMIS in March 2004 and is currently preparing to start the planning activities for a RFP that will require either modifications to or a replacement of the MMIS. The current MMIS contract ends on October 31, 2017 if the 2-year option is executed. The Enterprise recognizes that the upcoming MMIS RFP is an opportunity for enhancements to current business process maturities and to broaden the use of Enterprise services, products, and initiatives.

The first step in this process is to initiate planning and dialogue throughout the Enterprise to determine the overall MMIS procurement strategy. The Department must determine if it wishes to remediate the existing MMIS, attempt to retrofit its architecture to comply with contemporary technology and

interoperability needs, to break the MMIS into modular components, or to procure a complete replacement. Consideration will also be given to the impact of the statewide managed care model and what is needed or not needed in an MMIS to support this approach. The evaluation will also focus on how the MMIS can better serve the needs of the entire PME and comply with the latest MITA framework and 7C&S.

Goals and Objectives:
The following will be achieved during the MMIS procurement planning activities:

- Produce a procurement strategy that will transform the Medicaid Enterprise into a modular system utilizing open architecture and exposed services
- Explore how to expand the use of Enterprise solutions in the MMIS

Project Management Approach:
With limited resources due to the many projects and mandated initiatives currently underway, the Enterprise plans to procure outside expertise to conduct a feasibility study and CBA of the various options. Based on these results, the Department may further seek MMIS RFP and APD development support.

The planning process will be inclusive and establish a broad representation from across the Enterprise with a formal governance structure that aligns to Project Management approach detailed in Section 6.2.1.

Project Budget:
The cost of this project is estimated to be less than $2 million.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 55: MITA Maturity Gains from MMIS Procurement Planning

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
–	–
Business Relationship Management	**Health Plan Management**
–	PL01 – Develop Agency Goals and Objectives PL05 – Manage Performance Measures
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.6.2 MMIS Procurement

Duration:
Projected: October 2014 – July 2018

Description:
This project follows the MMIS Procurement Planning activities and involves the release, evaluation, and award of the MMIS contract(s) to procure the system(s) necessary to meet Enterprise goals and support

the defined procurement strategy. The details around this initiative will evolve as the MMIS planning activities occur.

Goals and Objectives:

The primary goal of the initial MMIS procurement activities is to issue a competitive RFP that articulates the defined procurement strategy and supports the MITA framework giving consideration to:

- The use of automation to improve processing time and efficiency
- Interoperable systems to improve data access and efficiency
- The use of a rules engine to separate the processing rules from the core system
- Increased electronic communications
- The use and incorporation of Enterprise solutions
- Seamless interaction with the HIE
- Utilizing workflow tools to automate processes and improve business results
- Achieving improvements in MITA maturity

Project Management Approach:

The Department plans to competitively procure the desired MMIS solution(s) in accordance with CMS and Commonwealth policy. The procurement activities will be supported by the established Project Management governance structure.

Project Budget:

TBD once the planning activities are completed.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 56: MITA Maturity Gains from the MMIS Procurement

Member Management	Provider Management
ME01 – Manage Member Information ME02 – Manage Applicant and Member Communication ME03 – Perform Population and Member Outreach ME08 – Manage Member Grievance and Appeal	PM01 – Manage Provider Information PM02 – Manage Provider Communication PM03 – Perform Provider Outreach PM07 – Manage Provider Grievance and Appeal PM08 – Terminate Provider
Financial Management	**Performance Management**
FM01 – Manage Provider Recoupment FM02 – Manage TPL Recovery FM03 – Manage Estate Recovery FM04 – Manage Drug Rebate FM05 – Manage Cost Settlement FM06 – Manage Accounts Receivable Information FM07 – Manage Accounts Receivable Collection/Refund FM08 – Prepare Member Invoice FM09 – Manage Invoice Payment FM10 – Manage Member Premium Payment FM11 – Manage Capitation Payment FM12 – Manage Incentive Payments FM13 – Manage Accounts Payable Information FM14 – Manage Accounts Payable Disbursement FM15 – Manage 1099s FM16 – Formulate Budget FM17 – Manage Budget Information	–

FM18 – Manage fund FM19 – Generate Financial Report	
Operations Management	**Care Management**
OM04 – Apply Attachment OM05 – Apply Mass Adjustment OM07 – Process Claim OM14 – Generate Remittance Advice OM18 – Inquire Payment Status OM20 – Calculate Spend Down Amount OM27 – Prepare Provider Payment OM28 – Manage Data OM29 – Process Encounter OM30 – Manage Drug Rebate Dispute Resolution OM31 – Manage Payment of Non-Emergency Transportation Claims	–
Business Relationship Management	**Health Plan Management**
BR01 – Establish Business Relationship BR02 – Manage Business Relationship Communication BR03 – Manage Business Relationship Information BR04 – Terminate Business Relationship	PL01 – Develop Agency Goals and Objectives PL05 – Manage Performance Measures PL07 – Manage Reference Information PL08 – Manage Rate Setting
Contractor Management	**Eligibility and Enrollment Management**
–	EE04 – Inquire Member Eligibility EE05 – Determine Provider Eligibility EE06 – Enroll Provider EE07 – Disenroll Provider EE08 – Inquire Provider Information

6.7 HIPAA and Other Federal Mandates

The projects in this last section are related to the HIPAA and other Federal initiatives. Each of the projects included in this section addresses the timeframe, goals and objectives, project management approach, and the proposed budget for the project being described, if known. At the end of each subsection, a table identifies the key MITA business processes that are impacted by the project.

6.7.1 Quality Measures – Waivers

Duration:
Ongoing

Description:
HCBS quality consists of four main areas:

- HCBS Quality History and FAQs
- CMS HCBS Quality Requirements
- HCBS Quality Resources
- National Technical Assistance in HCBS Quality (National Quality Enterprise (NQE))

CMS works in partnership with state agencies to assure and improve quality in Medicaid HCBS waiver programs. The goal of this effort is to maximize the quality of life, functional independence, health, and well-being of individuals served by the HCBS programs. The Pennsylvania OLTL has had significant interaction with this Federal initiative including requiring specific products such as the CMS waiver

application or providing additional insight into federal requirements. OLTL has also had involvement through the utilization of the new waiver applications and evidentiary report requirements.

OLTL has attended teleconferences regarding the AHRQ HCBS measures and provided input with OMAP. OLTL has also received technical assistance from the NQE numerous times in the past for applications and evidentiary reviews. OLTL is currently receiving NQE assistance for the global work plan, and the Aging and Attendant Care Waiver Evidentiary Based Reports.

OLTL has attended all educational forums provided by NQE (and CMS when possible) and hosted the forums for staff for ease of attendance and discussion. OLTL is also responsible to read, study, and distribute all available CMS developed and disseminated tools regarding quality systems such as monographs, PES surveys, quality framework, etc., to enhance staff knowledge.

Finally, within the next 5-years, OLTL anticipates utilizing the Continuous Quality Cycle, required by CMS, to continually upgrade its Quality Improvement System. Enhancements needed include the development and maintenance of a database for the collection, tracking and trending, and reporting on quality data. Such a system would eliminate manual counting, and allow accurate, timely aggregation and trending across OLTL waivers and programs, thereby simplifying documentation and reporting. OLTL will continue to study and follow current and future CMS quality initiatives to ensure compliance, and to maximize opportunities for quality improvement. OLTL expects to maintain a working relationship with NQE, the CMS Quality technical assistance provider.

Project Management Approach:

Activities and system changes related to this project will be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:

As activities that are eligible for enhanced funding are identified, the APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 57: MITA Maturity Gains from the Waiver Quality Measures

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
–	CM03 – Manage Population Health Outreach CM06 – Manage Treatment Plan and Outcomes CM09 – Authorize Treatment Plan
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.7.2 Quality Measures – Children's Health Insurance Program Reauthorization Act (CHIPRA)

Duration:

In Progress: February 2010 – January 2015

Description:

In February 2010, Pennsylvania was awarded $9.7 million from CMS under the CHIPRA Quality Demonstration Grant also known as Quality Improvement and Care for KidS Through Electronic ProgramS (QUICKSTEPS). The 5-year grant focuses on improving the quality of care for children enrolled in MA and CHIP.

Pennsylvania implemented projects in the following three grant categories:

- Showing how a core set of children's quality measures can be used to improve quality of care for children
- Promoting the use of HIT to enhance service quality and care coordination
- Demonstrating the impact of a model EHR format for children

The CHIPRA Quality Demonstration Grant has proven to be a valuable partner in the testing of the electronic submission of quality measures from the EHR and in the use of HIT in the delivery of children's healthcare. The information gathered from the CHIPRA demonstration has been useful in informing the overarching system of HIT enabling systems to be aligned for all purposes. This approach will aid healthcare in moving away from silos to the broad reaching interoperability of electronic healthcare delivery.

Lessons learned on the electronic extraction of quality measure data from the EHR include the need for the establishment of a standardized data gathering format that is communicated to EHR providers. Currently, not all necessary quality data is stored within discrete fields in the EHR. This can make it impossible to query certain data for reporting purposes. Patient payor information is often stored in a separate system from the EHR data making it difficult to stratify patients by insurance coverage. There is also a need for national standardized quality reporting specifications tailored for data collection at the physician level. Often, quality measures written at the health plan level have elements (such as continuous enrollment requirements) which are impossible to report at the provider level and require involvement by Medicare programs and health insurers.

CHIPRA has also tested the submission of quality data through the Department's Secure File Transfer Protocol (SFTP) site. Through this site, the electronically gathered EHR quality data is electronically sent from hospital systems to DPW. Data has been successfully gathered for 2-years using this method and has enabled DPW to understand that the electronic submission of data requires interoperability of data security systems, commonality of data format, and comparable bandwidth requirements. All of this becomes particularly important when collection of CQMs under meaningful use is examined.

CHIPRA has been working on exchanging information between the medical community and the OCDEL's Early Intervention offices. In the absence of a fully functioning HIE, CHIPRA is making plans to test the secure exchange of information using the DIRECT project. CHIPRA plans on moving to the use of DIRECT in 2013 to examine the benefits and potential barriers of the interoperability of various systems. This should provide insight for future technological improvements which may enhance the creation and use of the statewide HIE.

The testing of the Pediatric Electronic Health Record (PEHR) has fostered communication between healthcare providers and EHR vendors. Vendors are receiving "real world" information about how their systems perform when it comes to quality measure reporting, interoperability and the specialties involved

with children's healthcare such as weight-based dosing and growth charts. The feedback being provided to vendors enables them to implement improvements which will support future HIT interoperability.

The PEHR, in conjunction with Pennsylvania's HIE, will enable the sharing of medical information across health systems and will allow a child's medical record to follow them regardless of changes in geographic location or care providers. It is through the realm of HIT that Pennsylvania aims to improve health care quality for the pediatric population served by PA MA and CHIP.

Goals and Objectives:

The objectives of this demonstration project are:

- Improve the quality of care through the adoption of HIT by electronically extracting and reporting from EHRs
- Achieve bi-directional linkage with the Pennsylvania Statewide Immunization Information System (PA-SIIS) to allow for the electronic exchange of immunization data between the health systems and DOH
- Leverage HIT to maximize the early identification of children with developmental delay, behavioral health issues and those with complex medical conditions so their care can be closely coordinated with the Primary Care Provider (PCP) medical home, appropriate medical specialists and child serving social agencies
- Implement the CMS/Agency for Healthcare Research and Quality (AHRQ) PEHR model format template at the health systems participating in project

Project Management Approach:

DPW has partnered with the PID that oversees SCHIP and the Pennsylvania DOH that oversees the PA-SIIS. DPW is also partnering with seven health systems which give a varied snapshot of care across the state. Those partners are: Geisinger Health System, Children's Hospital of Philadelphia, St. Christopher's Hospital for Children, Children's Hospital of Pittsburgh of University of Pittsburgh Medical Center (UPMC), Hamilton Health Center, Penn State Hershey Medical Center, and Pocono Medical Center.

The health systems are testing the pediatric-specific model over the course of the 5-year grant to assess its effect on the quality of children's healthcare.

Project Budget:

The total amount of funding awarded for the 5-year grant is $9,794,571.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 58: MITA Maturity Gains from the CHIPRA Quality Measures

Member Management	Provider Management
ME01 – Manage Member Information	–
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
–	CM03 – Manage Population Health Outreach CM04 – Manage Registry CM06 – Manage Treatment Plan and Outcomes
Business Relationship Management	**Health Plan Management**
–	PL01 – Develop Agency Goals and Objectives PL04 – Manage Health Plan Information PL05 – Manage Performance Measures
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.7.3 Health Plan Identification (HPID)

Duration:
Projected: August 2013 – November 2016

Description:
Currently, health plans are identified in standard transactions using multiple identifiers that differ in length and format. Health care providers are frustrated by the lack of a standard identifier. The implementation of the HPID is expected to benefit health care providers, producing savings by decreasing the administrative time spent by physician practices interacting with health plans, and through the automation of processes for every transaction that moves from a manual transaction to an electronic transaction.

The regulation requires health plans to obtain an HPID by November 5, 2014, with small health plans having an extra year until November 5, 2015. Physicians will be required to include the HPID in claims and other HIPAA transactions on or after November 7, 2016.

This project will address the associated changes necessary for compliance with this regulation.

Goals and Objectives:
The following goals and objectives will be accomplished with this project:

- Meet the compliance requirements for implementing the HPID
- Increase standardization within the HIPAA standard transactions

Project Management Approach:
The project implementation will be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:
A Planning APD is being prepared for submission to CMS and will detail the estimated cost of this first phase.

Table 59: MITA Maturity Gains from the HPID Implementation

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
FM02 – Manage TPL Recovery	–
Operations Management	**Care Management**
–	–
Business Relationship Management	**Health Plan Management**
BR01 – Establish Business Relationship BR03 – Manage Business Relationship Information BR04 – Terminate Business Relationship	PL04 – Manage Health Plan Information
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.7.4 Administrative Simplification: Adoption of EFTs and ERA Transactions

Duration:
In Progress: June 2013 – September 2014

Description:
Compliance with a majority of the EFT and ERA standards and operating rules will be achieved by January 1, 2014, with full compliance by September 2014 with the completion of the Treasury Transformation Initiative described in Section 6.3.6 of this document. Implementation of the standards and operating rules is intended to improve the automation of heath care administrative processes and reduce costs related to EFT and ERA transactions.

The Department's objective is to complete the changes required by these mandates in a manner that will enhance the state's automated processes and optimize operational efficiencies. Additionally, the Department is coordinating the implementation of the EFT and ERA mandates with the implementation of the Treasury Transformation Initiative.

The Department has sent an APD to CMS for review and approval that includes the requirements for this project and explains how it will support the 7C&S.

Goals and Objectives:
The high level goals for this project include:

- Be in compliance with the EFT and ERA mandates by the compliance date
- Consider opportunities for automation and operational efficiency throughout the project
- Effectively coordinate financial system changes with the statewide treasury modernization initiative

Project Management Approach:
General project activities will include project management, detailed business requirements gathering, business design, systems testing, and provider communications. Providers will be notified of changes to current processes and systems.

Commonwealth staff will oversee and participate in the project governance as detailed in Section 6.2.1, Project Management. A Project Management Team has been selected to lead and oversee implementation. Primary project responsibilities are managed by the BDCM with support from the MMIS FA.

Project Budget:
Cost estimates are being developed for inclusion in the APD.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 60: MITA Maturity Gains from the EFT and ERA Mandates

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
FM13 – Manage Accounts Payable Information FM14 – Manage Accounts Payable Disbursement	–
Operations Management	**Care Management**
OM14 – Generate Remittance Advice OM27 – Prepare Provider Payment	–
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.7.5 Claim Attachments

Duration:
The timeline for this initiative is still TBD.

Description:
This project will support the Health Care Claim Attachment Provisions (1104I (3)) of PPACA. HHS is required to promulgate a final rule to establish a standard and a single set of operating rules for health claim attachments that is consistent with X12 version 5010 no later than January 1, 2014. Compliance is required by January 1, 2016.

The requirements of this project will be detailed in an APD once the operating rules are available.

Goals and Objectives:
The high level goals for this project include:

- Meet the January 1, 2016 compliance date to provide claim attachment functionality
- Support clinical and administrative electronic attachments to promote a national ability to connect and send value-added "packages" of information

Project Management Approach:
The project implementation will be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

Project Budget:
When the operating rules for claim attachments are released, the APD process will be initiated to request enhanced funding and provide project details.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 61: MITA Maturity Gains from the Claim Attachment Enhancements

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
OM04 – Apply Attachment OM07 – Process Claim	CM08 – Authorize Service CM09 – Authorize Treatment Plan
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.7.6 HIPAA: ICD-10

Duration:
In Progress: June 2011 – December 2014

Description:
The HIPAA ICD-10 project implements the enhancements to the MMIS and other Enterprise systems based on the final rules published by the U.S HHS under the Administrative Simplification provision of the HIPAA adoption of the ICD-10 standard. This project ensures the systems maintain compliance with HIPAA standards and adopts the use of ICD-10 diagnosis and procedure codes by October 1, 2014.

On January 16, 2009, the U.S. Department of HHS released the final rule mandating that entities covered by HIPAA implement ICD-10-CM for medical coding on October 1, 2014. The ICD-10-CM final rule concurrently adopted the ICD-10-CM for diagnosis coding, and the ICD-10-Procedure Coding System (PCS) for inpatient hospital procedure coding. These code sets replace the ICD-9-CM volumes 1 and 2, and the ICD-9-CM volume 3 for diagnosis and procedure codes, respectively. Covered entities that use these code sets include health plans, health care clearinghouses, and health care providers.

The Medicaid Enterprise, in conjunction with its contractors, completed an initial assessment of current codes vs. changes to be made per ICD-10-CM, and submitted a Planning Advance Planning Document (PAPD) to CMS for federal funding, which was approved. On April 9, 2012, a National Proposed Rule Making (NPRM) solicited comments concerning a delay of the implementation date. A decision was communicated in August 2012 that the compliance date was moved to October 1, 2014. The OMAP received approval of the IAPD for this project on April 5, 2013.

Goals and Objectives:
The primary goal of this project is to meet the federally mandated compliance date of October 1, 2014 for implementation of ICD-10 codes. Additionally, the Enterprise expects the adoption of the ICD-10 codes set to achieve the following:

- Support value-based purchasing and Medicare's anti-fraud and abuse activities by accurately defining services and providing specific diagnosis and treatment information
- Support comprehensive reporting of quality data
- Ensure more accurate payments for new procedures, fewer rejected claims, improved disease management, and harmonization of disease monitoring and reporting

- Allow the United States to compare its data with international data to track the incidence and spread of disease and treatment outcomes since the United States is one of the few developed countries not using ICD-10-CM

Project Management Approach:

The transition to ICD-10 has the potential to impact every system, process and transaction that uses, retains, or references diagnoses or inpatient procedure codes. Effects to the PME include:

- Coverage determinations
- Financial reporting
- Payment determinations
- Medical review policies
- Plan structures
- Statistical and actuarial projections
- Fraud and abuse monitoring

The project is considered an Enterprise level project. A dedicated project manager who is responsible for overseeing the project needs across the Enterprise was retained at the start of the planning phase.

The project is being managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management; however, it includes participation and representatives from a broader audience due to the impacts across the Enterprise.

Project Budget:

An IAPD for this phase of the project was approved on April 5, 2013 for $12,921,778.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 62: MITA Maturity Gains from the ICD-10 Implementation

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
OM07 – Process Claim OM28 – Manage Data OM29 – Process Encounter	–
Business Relationship Management	**Health Plan Management**
–	PL07 – Manage Reference Information PL08 – Manage Rate Setting
Contractor Management	**Eligibility and Enrollment Management**
–	–

6.7.7 Transformed Medicaid Statistical Information System (T-MSIS) Initiative

Duration:

Planning Phase: April 2013 – January 2014

Implementation Phase: February 2014 – July 2014

Description:

CMS has mandated the T-MSIS initiative in an effort to receive more complete and timely Medicaid and CHIP related data from all states. Medicaid Statistical Information System (MSIS) files are currently submitted to CMS quarterly. According to CMS, the data is incomplete, non-standard, and not timely enough to enable basic analysis. The new T-MSIS extract format and frequency is expected to further CMS goals for improved timeliness, reliability, and robustness through monthly updates and an increase in the amount of data requested.

To meet the needs of CMS, all states are required to meet the following data reporting requirements:

- Robust, flexible and repeatable data collection processes
- Valid, timely information for effective decision making
- Automation of manual tasks
- Standardized reporting
- Analytics for decision making
- Integration between management information systems

T-MSIS requires states to provide CMS with the following information for FFS, managed care, and CHIP data on a monthly basis by January 2014:

- An eligibility file
- Four detailed claims files which include Outpatient, Inpatient, LTC, and Pharmacy data
- A provider file (new to the process)
- A TPL file (new to the process)
- A managed care plan file (new to the process)

File layouts requirements and business rules are provided by CMS. Three tier CMS data validation edits will be required for each of the files.

Goals and Objectives:

The objectives of this project include:

- Ensure the accuracy of the data obtained from various systems (i.e., PROMISe™ and CIS)
- Implement internal validation edits consistent with CMS guidelines to ensure successful submissions
- Complete testing with CMS on all T-MSIS files and receive CMS approval of data
- Meet the January 2014 compliance date

Project Management Approach:

In support of this project, CMS is providing a State Liaison who will be a dedicated single point of contact to the Commonwealth. Orientation/readiness consultation, technical assistance an Implementation Toolkit is available to states to expedite the planning process and funding.

Project management activities will be conducted to address planning for the implementation approach and any required procurement activities, as related to the design and development of T-MSIS. Currently all activities fall into the planning category. The project implementation will be managed under the Department's standard project governance structure detailed in Section 6.2.1, Project Management.

A project management team has been selected to lead and oversee the planning of T-MSIS. The team is comprised of specialists from several bureaus within DPW. The SCHIP program area (Department of Insurance) will be consulted for possible inclusion in the PAPD.

Project Budget:

The estimated costs for the Planning Phase are $311,470. Once planning activities are completed, enhanced funding will be requested to support the implementation phase and included in the IAPD for this project.

The following MITA business processes will realize maturity gains through improved capabilities as a result of completing this initiative.

Table 63: MITA Maturity Gains from the T-MSIS Initiative

Member Management	Provider Management
–	–
Financial Management	**Performance Management**
–	–
Operations Management	**Care Management**
OM28 – Manage data	–
Business Relationship Management	**Health Plan Management**
–	–
Contractor Management	**Eligibility and Enrollment Management**
–	–

7.0 CONCLUSION

MITA is a national initiative promulgated by CMS. The MITA Framework version 3.0 establishes national guidelines for business processes and technologies that will enable the improved program administration of the PME. The MITA SS-A, which evaluates the PME, is required by CMS to be updated annually and is a required attachment to federal fund requests for technology projects. The PME is managed primarily by the DPW which manages the information that supports the Pennsylvania Medicaid program.

The Commonwealth has completed several key projects and objectives from it 2011 MITA SS-A. However, some key capabilities must still be met to fully move business, technical, and information capabilities to higher MMLs. While funding, resources, new state and federal initiatives, and staffing are key constraints in the successful completion of projects, the Commonwealth intends to fully utilize Federal funding opportunities to complete the projects on its To Be Roadmap.

On a scale of MML 1 to Level 5, the PME in large part was assessed at Level 1 with a goal to be at Level 2 within a 5-year timeframe. The Commonwealth will continue to move forward with projects and integrate the MITA framework onto project management and governance.

Of the 26 projects included in the To Be Roadmap, 19 are required by the Commonwealth legislature, federal, or judicial mandates. Thirteen projects are currently in process. Two projects currently in progress (member and provide module enhancements) are well positioned to accommodate additional requirements from projects outside the Commonwealth. Six of the projects are scheduled to start in the next three months (June to August 2013). Where applicable, each project was linked to one or many corresponding MITA Business Processes. These projects will enhance the Commonwealth's ability to improve efficiency and services for its stakeholders through the use of standard interfaces and SOA.

As Pennsylvania completes improvements identified in the To Be Roadmap, the net effect is that the To Be items identified in Pennsylvania's MITA Maturity Capability Matrix become the new As Is. There would be milestones set that will keep the SS-A current to within 2-years of each assessment. These ongoing assessment cycles should ensure that the appropriate business process and technical capability documentation remains current and that new To Be Maturity Levels are established. This, in turn, will establish the foundation for planning subsequent projects, thus streamlining the planning process and supporting the new methodology chosen to support the Medicaid Enterprise.

This SS-A was completed using the BA and TA defined in version 3.0 of the MITA Framework. Updates will continue to be made to the MITA Framework and periodic updates to the Pennsylvania MITA SS-A will be required.

Appendix A: MITA SS-A Scorecards

7.1 A.1 Scorecards

The content for this appendix has been posted to Docushare and can be accessed through the following link: http://docushare.dpw.lcl/docushare/dsweb/View/Collection-68826

- BA
- IA
- TA
- 7C&S

Appendix B: MITA SS-A Session Details

7.2 B.1 MITA SS-A Session Details

The content for this appendix has been posted to Docushare and can be accessed through the following link: http://docushare.dpw.lcl/docushare/dsweb/View/Collection-68826

Appendix C: Acronyms

Acronym	Definition
7C&S	Seven Conditions and Standards
AAAs	Area Agencies on Aging
ACA	Affordable Care Act
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immunodeficiency Syndrome
ANSI	American National Standards Institute
AP	Application Processing
APD	Advance Planning Document
API	Application Programming Interface
ARRA	American Recovery and Reinvestment Act
AVRS	Automated Voice Response System
BA	Business Architecture
BAFO	Best and Final Offer
BAS	Bureau of Administrative Services
BAS	Bureau of Autism Services
BCM	Business Capability Matrix
BCSEP	Bureau of Child Support Enforcement Programs
BDCM	Bureau of Data and Claims Management
BETP	Bureau of Employment and Training Programs
BFFSP	Bureau of Fee-for-Service Programs
BFH	Bureau of Family Health
BFO	Bureau of Financial Operations
BHA	Bureau of Hearings and Appeals
BIS	Bureau of Information Systems
BMCO	Bureau of Managed Care Operations
BO	Bureau of Operations
BPAP	Bureau of Policy, Analysis, and Planning
BPI	Bureau of Program Integrity
BP	Bureau of Policy
BPE	Bureau of Program Evaluation
BPEL	Business Process Execution Language
BPM	Business Process Modeling
BPO	Business Process Optimization
BPS	Bureau of Provider Support
BR	Business Relationship
BRM	Business Relationship Management
CAH	Critical Access Hospitals
CAO	County Assistance Office
CAPS	CHIP and Adult-Basic Processing System
CAQH	Council for Affordable Quality Healthcare
CBA	Cost Benefit Analysis
CLIA	Clinical Laboratory Improvement Amendment
CSS	Community Shared Services
CDC	Center for Disease Control

Acronym	Definition
CDM	Conceptual Data Model
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CI-HIE	Commonwealth Internal Health Information Exchange
CIS	Client Information System
CM	Care Management
CMDB	Configuration Management Data Base
CMS	Centers for Medicare & Medicaid Services
CO	Contractor Management
COB	Coordination of Benefits
COBOL	Common Business Oriented Language
COMPASS	The Commonwealth of Pennsylvania Access to Social Services
COO	Concept of Operations
COOP	Continuity of Operations
CORE	Committee on Operating Rules for Information Exchange
COTS	Commercial Off-the-Shelf
CQM	Clinical Quality Measures
CRM	Customer Relationship Management
DDI	Design, Development, and Implementation
DEA	Drug Enforcement Agency
DESI	Drug Efficacy Study and Implementation
DGS	Department of General Services
DHHS	Federal Department of Health and Human Services
DHS	Department of Human Services
DIAS	Data Investigations and Analysis Section
DIRECT	Depression Information Resource & Education Centre
DLI	Department of Labor and Industry
DMVA	Department of Military and Veteran's Affairs
DOH	Department of Health
DOI	Digital Object Identifier
DOR	Department of Revenue
DOS	Department of State
DPW	Department of Public Welfare
DR	Disaster Recovery
DSM IV	Diagnostic and Statistical Manual, of Mental Disorders, version 4
EBT	Electronic Bank Transfer
eCIS	Electronic Client Information System
ECM	Enterprise Content Management
ED	Electronic Data
EDI	Electronic Data Interchange
EDM	Electronic Data Management
EDM	Electronic Document Management
EDW	Enterprise Data Warehouse
EDX	Enterprise Data Exchange
EE	Eligibility and Enrollment Management

Acronym	Definition
EFT	Electronic Funds Transfers
EHR	Electronic Health Record
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
ePEAP	Electronic Provider Enrollment Automation Project
EPLS	Excluded Parties List System
EPMM	Enterprise Project Management Methodology
ERA	Electronic Remittance Advice
eRFP	Electronic Request for Proposal
ERP	Enterprise Resource Planning
ESB	Enterprise Service Bus
ETL	Extract, Transform, and Load
EVS	Executive Visioning Sessions
EVS	Eligibility Verification System
FA	Fiscal Agent
FADS	Fraud and Abuse Detection System
FAQs	Frequently Asked Questions
FFM	Federally Facilitated Marketplace
FFP	Federal Financial Participation
FFS	Fee-for-Service
FM	Financial Management
FMAP	Federal Medical Assistance Percentage
FS	Food Stamps
FWA	Fraud, Waste, and Abuse
GA	General Assistance
GAAP	Generally Accepted Accounting Principles
GASB	Governmental Accounting Standards Board
GIS	Geographical Interface System
HCBS	Home and Community Based Services
HCSIS	Home and Community Services Information System
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act
HIPDB	Healthcare Integrity Practitioner Data Bank
HIPP	Health Insurance Premium Payments
HISP	Health Information Service Providers
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HIX	Health Insurance Exchange
HMS	Healthcare Management System
HPES	Hewlett-Packard Enterprise Services
HPID	Health Plan Identification
HRSA	Health Resources and Services Administration

Acronym	Definition
IA	Information Architecture
IAPD	Implementation Advance Planning Document
IAPDU	Implementation Advance Planning Document Update
ICD-10	International Classification of Diseases and Related Health Problems, Tenth Revision
iCIS	Integrated Client Information System
ID	Identification
IRS	Internal Revenue Service
ISP	Individual Support Plan
IT	Information Technology
IVR	Interactive Voice Response
JAD	Joint Application Development
KPI	Key Performance Indicators
LDM	Logical Data Model
LEIE	List of Excluded Individuals/Entities
LIHEAP	Low Income Home Energy Assistance Program
LTC	Long-Term Care
MA	Medical Assistance
MAAC	Medical Assistance Advisory Committee
MAGI	Modified Adjusted Gross Income
MAHIT	Medical Assistance Health Information Technology
MAPIR	Medical Assistance Provider Incentive Repository
MAPPER	Maintaining, Preparing, and Processing Executive Reports
MATP	Medical Assistance Transportation Program
MAWD	Medicaid Assistance for Workers with Disabilities
MCI	Master Client Index
MCO	Managed Care Organization
ME	Member Management
MECT	Medicaid Enterprise Certification Toolkit
MFCU	Medicaid Fraud Control Unit
MH/MR	Mental Health/Mental Retardation
MHS	Magellan Health Services
MITA	Medicaid Information Technology Architecture
MITS	Medicaid Information Technology Supplement
MMIS	Medicaid Management Information System
MML	MITA Maturity Level
MMM	MITA Maturity Model
MOU	Memorandum of Understanding
MPI	Master Provider Index
MSIS	Medicaid Statistical Information System
NCCI	National Correct Coding Initiative
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Codes
NLR	National Level Repository
NPPES	National Plan and National Plan & Provider Enumeration System Provider Enumeration System

Acronym	Definition
NPI	National Provider Identifier
NPRM	National Proposed Rule Making
NQE	National Quality Enterprise
NwHIN	Nationwide Health Information Network
OA	Office of Administration
OAG	Office of the Attorney General
OB	Office of Budget
OCDEL	Office of Child Development and Early Learning
OCR	Optical Character Recognition
OCQI	Office of Clinical Quality Improvement
OCSA	Office of Community Services and Advocacy
OCYF	Office of Children, Youth, and Families
ODP	Office of Developmental Programs
OGC	Office of General Counsel
OIG	Office of the Inspector General
OIM	Office of Income Maintenance
OIT	Office of Information Technology
OLA	Office of Legislative Affairs
OLRM	Office of Licensing and Regulatory Management
OLTL	Office of Long-Term Living
OM	Operations Management
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
ONC	Office of the National Coordinator
OPC	Office of Press and Communications
OPD	Office of Policy Development
P4P	Pay for Performance
PA	Pennsylvania
PA	Prior Authorization
PAID	Program Access improving Daily
PAPD	Planning Advanced Planning Document
PA-SIIS	Pennsylvania Statewide Immunization Information System
PBM	Pharmacy Benefits Management
PC	Personal Computer
PCCM	Primary Care Case Manager
PCP	Primary Care Provider
PCS	Procedure Coding System
PDA	Pennsylvania Department of Aging
PDE	Pennsylvania Department of Education
PDF	Portable Document Format
PDL	Preferred Drug List
PE	Performance Management
PEAP	Provider Enrollment Automation Project
PELICAN	Pennsylvania Enterprise to Link Information for Children Across Networks
PES	Provider Electronic Solutions
PEHR	Pediatric Electronic Health Record

Acronym	Definition
PHI	Protected Health Information
PID	Pennsylvania Insurance Department
PIP	Provider Incentive Payment program
PL	Plan Management
PM	Provider Management
PMA	Pennsylvania Medicaid Agency
PME	Pennsylvania Medicaid Enterprise
POAM	Plan of Action with Milestones
POS	Point of Service
PPACA	Patient Protection Affordable Care Act
PR	Provider Repository
PRIMS	Pharmacy Rebate Information Management System
ProDUR	Prospective Drug Utilization Review
PROMISe™	Provider Reimbursement and Operations Management Information System
QA	Quality Assurance
QUICKSTEPS	Quality Improvement and Care for Kids Through Electronic Programs
R&A	Registration and Attestation System
RA	Remittance Advice
REOMB	Recipient Explanation of Medicare Benefits
RESTful	Representational State Transfer
RetroDUR	Retrospective Drug Utilization Review
RFP	Request for Proposal
RFQ	Request for Quotation
RHIO	Regional Health Information Organization
RID	Recipient Identification Number
ROI	Return on Investment
ROSI	Reconciliation of State Invoice
Rx	Pharmacy
SAMS	Social Assistance Management System
SAP	Systems, Applications, and Products
SAS	Statistical Analytical System
SAT	System Acceptance Testing
SBP	State Blind Pension
SCHIP	State Children's Health Insurance Program
SDLC	System Development Life Cycle
SDO	Standards Development Organization
SFTP	Secure File Transfer Protocol
SLA	Service Level Agreement
SMA	State Medicaid Agency
SME	Subject Matter Expert
SMHP	State Medicaid Health Information Technology Plan
SNAP	Supplemental Nutrition Assistance Program
SOA	Service-Oriented Architecture
SOAP	Simple Object Access Protocol
SPA	State Plan Amendment
SPBP	Special Pharmaceutical Benefits Program

Acronym	Definition
SQL	Structured Query Language
SRM	Supplier Relationship Management
SSA	Social Security Administration
SS-A	State Self-Assessment
SSI	Supplemental Security Income
SSO	Single Sign-On
STD	Sexually Transmitted Disease
SUR	Surveillance and Utilization Review
TA	Technical Architecture
TABS	Treasury Department Automated Bookkeeping System
TANF	Temporary Assistance to Needy Families
TB	Tuberculosis
TBD	To Be Determined
TCM	Technical Capability Matrix
T-MSIS	Transformed Medicaid Statistical Information Systems
TPL	Third-Party Liability
UAT	Universal Acceptance Testing
UML	Unified Modeling Language
UPMC	University of Pittsburg Medical Center
UI	User Interface
USCIS	U.S. Citizenship and Immigration Services
USPS	United States Postal Service
VAN	Virtual Area Network
WSDL	Web Services Definition Language
XML	Extensible Markup Language

Appendix D: State profile

7.3 D.1 BA Profile

The BA Profile illustrates the business capabilities for each business area reviewed in the DPW SS-A. The table articulates the As Is and To Be Maturity Levels for each business area in the format specified by the MITA Framework 3.0, SS-A Companion Guide. The BA profile will be reviewed by CMS for increasing advancement across the Maturity Levels.

BA Profile Business Relationship Management Business Process					
	Level 1	***Level 2***	***Level 3***	***Level 4***	***Level 5***
BR01 - Establish Business Relationship	As Is	To Be			
BR02 - Manage Business Relationship Communication	As Is	To Be			
BR03 - Manage Business Relationship Information	As Is	To Be			
BR04 - Terminate Business Relationship	As Is	To Be			

BA Profile Care Management Business Process					
	Level 1	***Level 2***	***Level 3***	***Level 4***	***Level 5***
CM01 - Establish Case	As Is	To Be			
CM02 - Manage Case	As Is	To Be			
CM03 - Manage Population Health Outreach	As Is	To Be			
CM04 - Manage Registry	As Is	To Be			
CM05 - Perform Screening & Assessment	As Is	To Be			
CM06 - Manage Treatment Plan & Outcomes	As Is	To Be			
CM07 - Authorize Referral	N/A	N/A			
CM08 - Authorize Service	As Is	To Be			
CM09 - Authorize Treatment Plan	As Is	To Be			

BA Profile Contractor Management Business Process					
	Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
CO01 - Manage Contractor Information	As Is	To Be			
CO02 - Manage Contractor Communication	As Is	To Be			
CO03 - Perform Contractor Outreach	As Is	To Be			
CO04 - Inquire Contractor Information	As Is	To Be			
CO05 - Produce Solicitation	As Is	To Be			
CO06 - Award Contract	As Is	To Be			
CO07 - Manage Contract	As Is	To Be			
CO08 - Close Out Contract	As Is	To Be			
CO09 - Manage Contractor Grievance & Appeal	As Is	To Be			

BA Profile Eligibility & Enrollment Management Business Process					
	Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
EE01 - Determine Member Eligibility	As Is		To Be		
EE02 - Enroll Member	As Is		To Be		
EE03 - Disenroll Member	As Is		To Be		
EE04 - Inquire Member Eligibility	As Is	To Be			
EE05 - Determine Provider Eligibility	As Is	To Be			
EE06 - Enroll Provider	As Is	To Be			
EE07 - Disenroll Provider	As Is	To Be			
EE08 - Inquire Provider Information	As Is	To Be			

BA Profile Financial Management Business Process					
	Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
FM01 - Manage Provider Recoupment	As Is	To Be			
FM02 - Manage TPL Recovery	As Is	To Be			
FM03 - Manage Estate Recovery	As Is	To Be			
FM04 - Manage Drug Rebate		As Is To Be			
FM05 - Manage Cost Settlement	As Is	To Be			
FM06 - Manage Accounts Receivable Funds	As Is	To Be			
FM07 - Manage Accounts Receivable Collection	As Is	To Be			
FM08 - Prepare Member Premium Invoice	As Is	To Be			
FM09 - Manage Contractor Payment	As Is	To Be			
FM10 - Manage Member Financial Participation	As Is	To Be			
FM11 - Manage Capitation Payment	As Is	To Be			
FM12 - Manage Incentive Payment		As Is	To Be		
FM13 - Manage Accounts Payable Information	As Is	To Be			
FM14 - Manage Accounts Payable Disbursement	As Is	To Be			
FM15 - Manage 1099		As Is To Be			
FM16 - Formulate Budget	As Is	To Be			
FM17 - Manage Budget Information	As Is	To Be			
FM18 - Manage Fund	As Is	To Be			
FM19 - Generate Financial Report	As Is	To Be			

BA Profile Member Management Business Process					
	Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
ME01 - Manage Member Information	As Is		To Be		
ME02 - Manage Applicant & Member Communication	As Is	To Be			
ME03 - Perform Population & Member Outreach	As Is	To Be			
ME08 - Manage Member Grievance & Appeal	As Is	To Be			

BA Profile Operations Management Business Process					
	Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
OM04 – Submit Electronic Attachment	As Is	To Be			
OM05 - Apply Mass Adjustment		As Is To Be			
OM07 - Process Claim	As Is	To Be			
OM14 - Generate Remittance Advice	As Is	To Be			
OM18 - Inquire Payment Status		As Is To Be			
OM20 - Calculate Spend-Down Amount	As Is	To Be			
OM27 - Prepare Provider Payment	As Is	To Be			
OM28 - Manage Data	As Is	To Be			
OM29 - Process Encounter	As Is	To Be			
OM30 – Manage Drug Rebate Dispute Resolution	As Is	To Be			
OM31 – Manage Payment of Non-Emergency Transportation	As Is	To Be			

BA Profile Performance Management Business Process					
	Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
PE01 - Identify Utilization Anomalies		As Is To Be			
PE02 - Establish Compliance Incident	As Is	To Be			
PE03 - Manage Compliance Incident Information	As Is	To Be			
PE04 - Determine Adverse Action Incident	As Is	To Be			
PE05 - Prepare REOMB	As Is	To Be			

BA Profile Plan Management Business Process					
	Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
PL01 - Develop Agency Goals & Objectives	As Is	To Be			
PL02 - Maintain Program Policy	As Is	To Be			
PL03 - Maintain State Plan	As Is	To Be			
PL04 - Manage Health Plan Information	As Is	To Be			
PL05 - Manage Performance Measures		As Is To Be			
PL06 - Manage Health Benefit Information	As Is	To Be			
PL07 - Manage Reference Information	As Is	To Be			
PL08 - Manage Rate Setting	As Is	To Be			

BA Profile Provider Management Business Process					
	Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
PM01 - Manage Provider Information	As Is		To Be		
PM02 - Manage Provider Communication	As Is	To Be			
PM03 - Perform Provider Outreach	As Is	To Be			
PM07 - Manage Provider Grievance & Appeal	As Is	To Be			
PM08 - Terminate Provider	As Is	To Be			

7.4 D.2 IA Profile

The IA Profile illustrates the information capabilities for each business area in the MITA Framework 3.0. The table articulates the As Is and To Be Maturity Levels for each business area in the format specified by the MITA Framework 3.0, SS-A Companion Guide. The IA profile will be reviewed by CMS for increasing advancement across the Maturity Levels.

IA Profile					
Business Area	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Relationship Management	As Is	To Be			
Care Management	As Is	To Be			
Contractor Management	As Is	To Be			
Eligibility & Enrollment Management	As Is	To Be			
Financial Management	As Is	To Be			
Member Management	As Is	To Be			
Operations Management	As Is	To Be			
Performance Management	As Is	To Be			
Plan Management	As Is	To Be			
Provider Management	As Is	To Be			

7.5 D.3 TA Profile

The TA Profile illustrates the technical capabilities for each business area in the MITA Framework 3.0. The table articulates the As Is and To Be Maturity Levels for each business area in the format specified by the MITA Framework 3.0, SS-A Companion Guide. The TA profile will be reviewed by CMS for increasing advancement across the Maturity Levels.

Technical Architecture Profile					
Business Area	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Business Relationship Management	As Is	To Be			
Care Management	As Is	To Be			
Contractor Management	As Is	To Be			
Eligibility & Enrollment Management	As Is	To Be			
Financial Management	As Is	To Be			
Member Management	As Is	To Be			
Operations Management	As Is	To Be			
Performance Management	As Is	To Be			
Plan Management	As Is	To Be			
Provider Management	As Is	To Be			

7.6 D.4 7C&S Profile

The table below displays the As Is operations and To Be environment for the DPW based on the 7C&S for the business processes in the MITA Framework 3.0. The 7C&S profile will be reviewed by CMS for increasing advancement across the Maturity Levels.

7C&S Profile		
MITA Business Area	**As Is Level of Business Capability**	**To Be Level of Business Capability**
Business area: Business Relationship Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 2
Reporting Condition	Level 1	Level 2

7C&S Profile		
MITA Business Area	**As Is Level of Business Capability**	**To Be Level of Business Capability**
Interoperability Condition	Level 1	Level 2
Business area: Care Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 2
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 1	Level 2
Business area: Contractor Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 2
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 1	Level 2
Business area: Eligibility & Enrollment Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 3
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 2

7C&S Profile		
MITA Business Area	**As Is Level of Business Capability**	**To Be Level of Business Capability**
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 1	Level 2
Business area: Financial Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 2
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 1	Level 2
Business area: Member Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 3
Business Results Condition	Level 1	Level 3
Reporting Condition	Level 1	Level 3
Interoperability Condition	Level 1	Level 4
Business area: Operations Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2

7C&S Profile		
MITA Business Area	**As Is Level of Business Capability**	**To Be Level of Business Capability**
Business Results Condition	Level 2	Level 2
Reporting Condition	Level 2	Level 2
Interoperability Condition	Level 1	Level 2
Business area: Performance Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 2	Level 2
Reporting Condition	Level 2	Level 2
Interoperability Condition	Level 1	Level 2
Business area: Plan Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 2
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 1	Level 2
Business area: Provider Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 4	Level 5
Industry Standards Condition	Level 1	Level 3

7C&S Profile		
MITA Business Area	**As Is Level of Business Capability**	**To Be Level of Business Capability**
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 2
Reporting Condition	Level 2	Level 2
Interoperability Condition	Level 1	Level 2

Appendix E: Technical Survey Results

7.7 E.1 Technical Survey Results

The content for this appendix has been posted to Docushare and can be accessed through the following link: http://docushare.dpw.lcl/docushare/dsweb/View/Collection-68826