Division of Medicaid & Long-Term Care

Medicaid Information Technology Architecture 3.0 State Self-Assessment

(MITA 3.0 SS-A)

March 19, 2015

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1. Executive Summary

1.1. SS-A Background/Purpose

The Centers for Medicare & Medicaid Services (CMS) requires that a State Medicaid agency (SMA) complete a Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) prior to approval of federal financial participation (FFP) for enhancements to or replacement of a Medicaid Management Information System (MMIS). This assessment includes a comprehensive review of a state's business, information, and technical processes using the MITA framework.

MITA is a business-centric initiative designed to stimulate an integrated business and information technology (IT) transformation within Medicaid agencies. MITA can improve Medicaid program administration by aligning business processes and supporting technology with national guidelines.

This document assesses how well the SMA's enterprise architecture (EA) meets current and anticipated business imperatives and evaluates relevant strengths, opportunities for improvement, and risks. Included is a Roadmap that clearly identifies the initiatives and projects that are improving, and will continue to improve, the SMA's MITA maturity levels (CMS specifies and defines MITA maturity levels between one and five. The definition of each level is available in Appendix C [Business Capability/Level of Maturity]). The goal of this assessment process is to make smart, informed decisions about how to bring future business, information, and technical architectures to higher levels of MITA maturity, thereby improving the responsiveness, nimbleness, and cost-effectiveness of Nebraska's Medicaid program.

1.2. MITA Initiative

MITA is intended to provide states with a framework for improving Medicaid business processes and exchanging data with members, vendors and service providers, state Medicaid agencies, CMS, and other agencies and programs.

MITA supports a technology structure to communicate and exchange data across many sites and organizations. It also encourages:

- Improvements in program monitoring and the quality of care through data sharing
- Efficient use of resources through the sharing of reusable software
- Timely responses to program changes and emerging health needs
- Improvements in access to high quality information for clients and providers, to enable more informed health care decisions

1.3. Nebraska SS-A Project Scope and Assessment Process

The scope of this SS-A includes an assessment of all three MITA architectures across the State Medicaid Agency (SMA) enterprise:

- Business architecture (BA)
- Information architecture (IA)
- Technical architecture (TA)

The BA scope includes 10 business areas and 80 business processes. The team used the MITA 2.0 SS-A report and artifacts, and conducted sessions with the Division of Medicaid and Long-Term Care (MLTC) subject matter experts (SMEs), Administrators, and Deputy Directors; as well as SMEs from other Nebraska Department of Health and Human Services (DHHS) entities such as Finance and the Information Systems and Technology (IS&T) Division (the latter operates jointly under DHHS and the Office of the Chief Information Officer [OCIO]) to complete the assessment. Based on the information gathered, MITA maturity levels for the As-Is state were assessed for each business process. To-Be maturity was assessed based on the anticipated impact of existing or planned projects (Eligibility and Enrollment Solution [EES] and MMIS, for example) and other identified opportunities.

The IA and TA assessments analyzed Medicaid systems and processes including:

- MMIS
- N-FOCUS (Nebraska Family Online Client User System)
- CONNECT (Coordinating Options in Nebraska's Network Through Effective Communications & Technology)
- Provider Information/Enrollment website
- NMES AVRS (Nebraska Medicaid Eligibility System, Automated Voice Response System for Medicaid Eligibility)
- VRU (N-FOCUS Voice Response Unit)
- MDR (Medicaid Drug Rebate)
- Trading Partner Application database
- KoDak Prior Authorization
- Casemix – Processes Medicaid resident assessment and care screen records

1.4. Business Architecture Summary

In the MITA 3.0 Framework, there are 10 business areas that encompass 80 business processes:

Business Area	Number of Business Processes
Business Relationship Management	4
Care Management	9
Contractor Management	9
Eligibility & Enrollment Management	8
Financial Management	19
Member Management	4
Operations Management	9
Performance Management	5
Plan Management	8
Provider Management	5
TOTAL	80

Table 1 - Nebraska MITA Business Area Breakdown

Nebraska's MITA business areas and business processes are, for the most part, at a Level 1 MITA maturity. This is mainly due to one or more of the following reasons:

- Outdated and/or limited documentation of business processes
- Lack of uniform data management standards and practices
- Limited performance measurement, including stakeholder satisfaction, for most business processes
- Lack of standardized process capability/coordination
- Legacy systems with limited flexibility to keep pace with changes in technology, legislation, and regulations
- Limited ability to interface with other systems

While not all business areas and business processes are affected by each of these reasons, most are affected by at least one of them.

Figure 1 provides a summary of As-Is and To-Be maturity levels by business area. The maturity levels shown, as with all maturity level scoring performed during this assessment (per CMS guidance), list the minimum maturity level within the business area. So, if, for example, a business area has four processes, with three processes assessing at a Level 3 and one process scoring at a Level 2, the business area is scored at a Level 2.

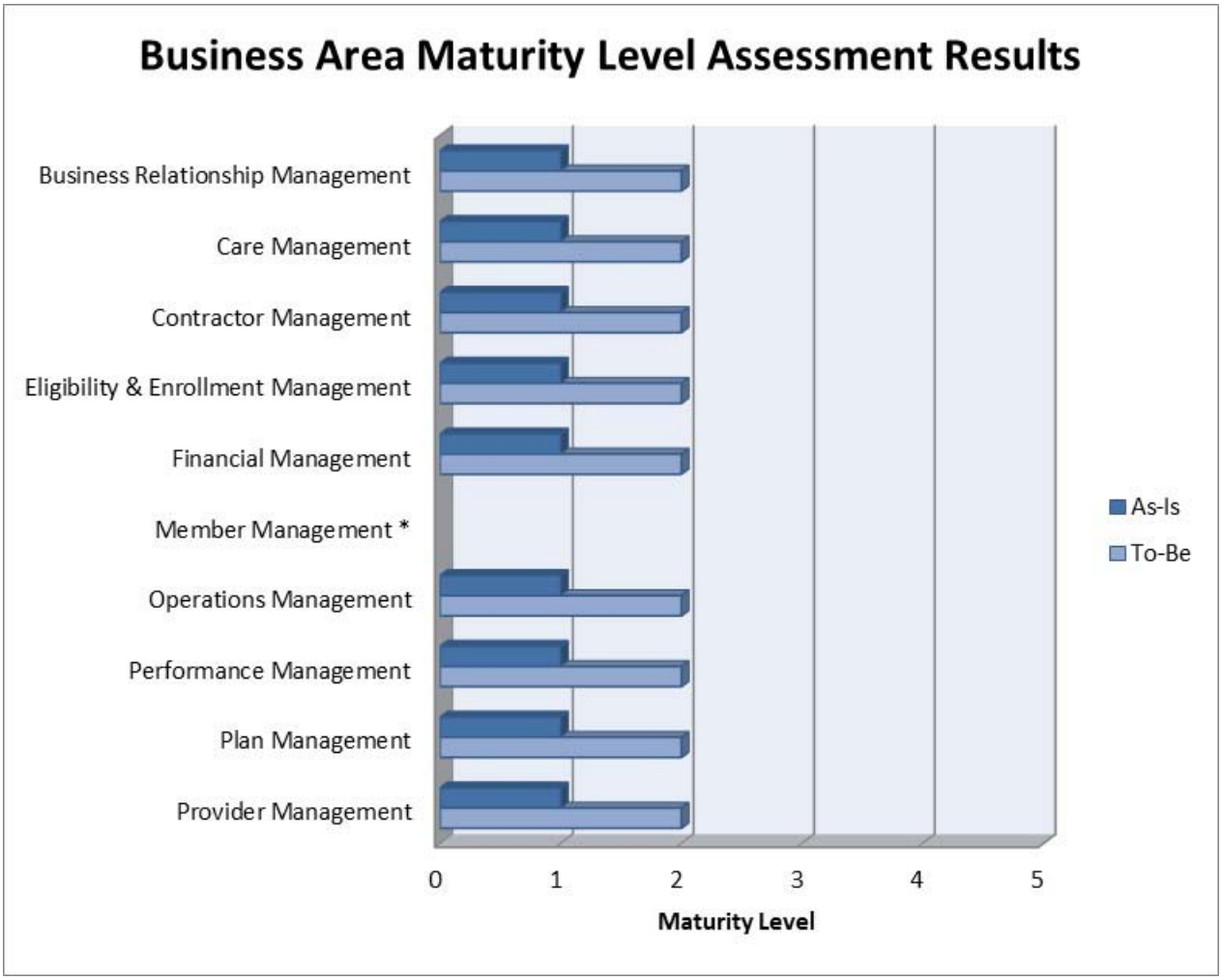


Figure 1 - Business Area Maturity Level Assessment Results

*__NOTE__: The Member Management business area has not been finalized by CMS, and as a result, scoring will be completed once the business processes are finalized.

By implementing projects listed in the MITA Roadmap (and discussed in this document), MITA maturity levels will rise in almost every area. From a BA perspective, the following projects will have an impact on almost all areas of the enterprise:

- MMIS replacement
- MITA transformation (a collection of smaller projects and initiatives)
- Enterprise data management strategy
- Performance measures
- Standard operating procedures (SOPs)
- Enterprise workflow management strategy

1.5. Information Architecture Summary

In the MITA 3.0 Framework, the IA is comprised of five components:

- Data management strategy
- Logical data model
- Data standards
- Conceptual data model
- Information capability matrix

Nebraska's MITA IA components are, for the most part, at a Level 1 MITA maturity level. This is mainly due to one or more of the above components not existing or not being utilized for the systems that support the business processes assessed within the SS-A. For example, some systems do not have a conceptual or logical data model, some systems are not governed by a data management strategy, and some systems do not have documented data standards.

While not all business areas/processes are affected by each of these reasons, most are affected by at least one of them. Figure 2 provides a summary of As-Is and To-Be maturity levels by business area. For each business area maturity level, the lowest maturity level among the five IA components was used.

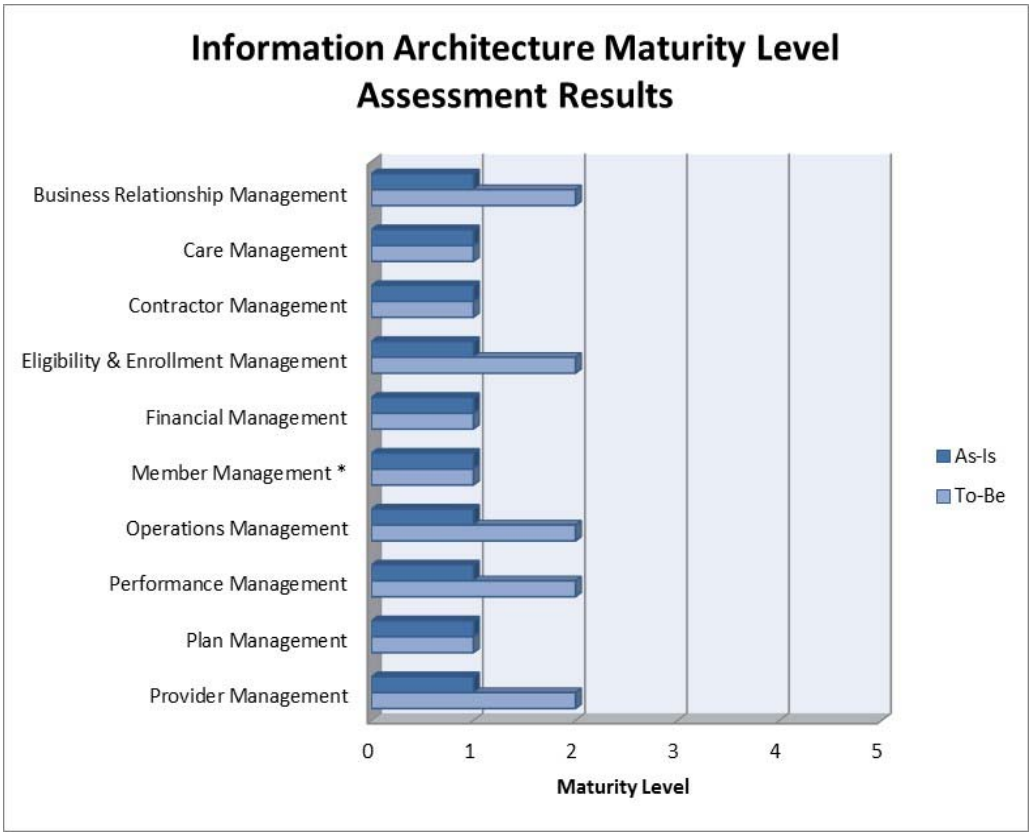


Figure 2 - Information Architecture Maturity Level Assessment Results

By implementing projects listed in the MITA Roadmap, MITA maturity levels will increase in almost every area. From an IA perspective, while most of the projects on the MITA Roadmap are important, the following projects will have the largest impact on the IA:

- MMIS replacement
- Provider screening and enrollment (PS&E)
- Eligibility and enrollment system (EES)
- MITA transformation
- Enterprise data management strategy

1.6. Technical Architecture Summary

The MITA 3.0 Framework describes an approach for advancing the Medicaid Technical Architecture (TA) to a new level of capability. This new MITA-aligned TA will improve the Nebraska Medicaid program and position MLTC for a new generation of business systems.

The MITA TA is comprised of the following 15 technical functions:

- Client support

- Business intelligence
- Forms and reporting management
- Performance measurement
- Security and privacy
- Business process management
- Relationship management
- Data connectivity
- Service oriented architecture
- System extensibility
- Configuration management
- Data access and management
- Decision management
- Logging
- Utility

The overall current state of Nebraska Medicaid's IT systems and the average MITA TA capability maturity levels are at a level 1 or the lowest level. This is mainly due to one or more of the above functions not existing or not being utilized for the systems that support the technical function assessed within the SS-A. For example, none of the systems support the MITA service-oriented architecture (SOA) framework; in addition, most systems are not utilizing the system extensibility technical function, are not governed by a configuration management function, or do not meet all of the utility technical function.

From a TA perspective, there were a number of opportunities that emerged from the Technical Assessment. Each was considered to determine its impact on the MITA TA maturity levels. Figure 3, Technical Architecture Technical Service Areas Maturity Level Assessment Results, provides a summary of the As-Is and To-Be maturity levels by technical function. For each technical function, the lowest maturity level among the assessed systems was used.

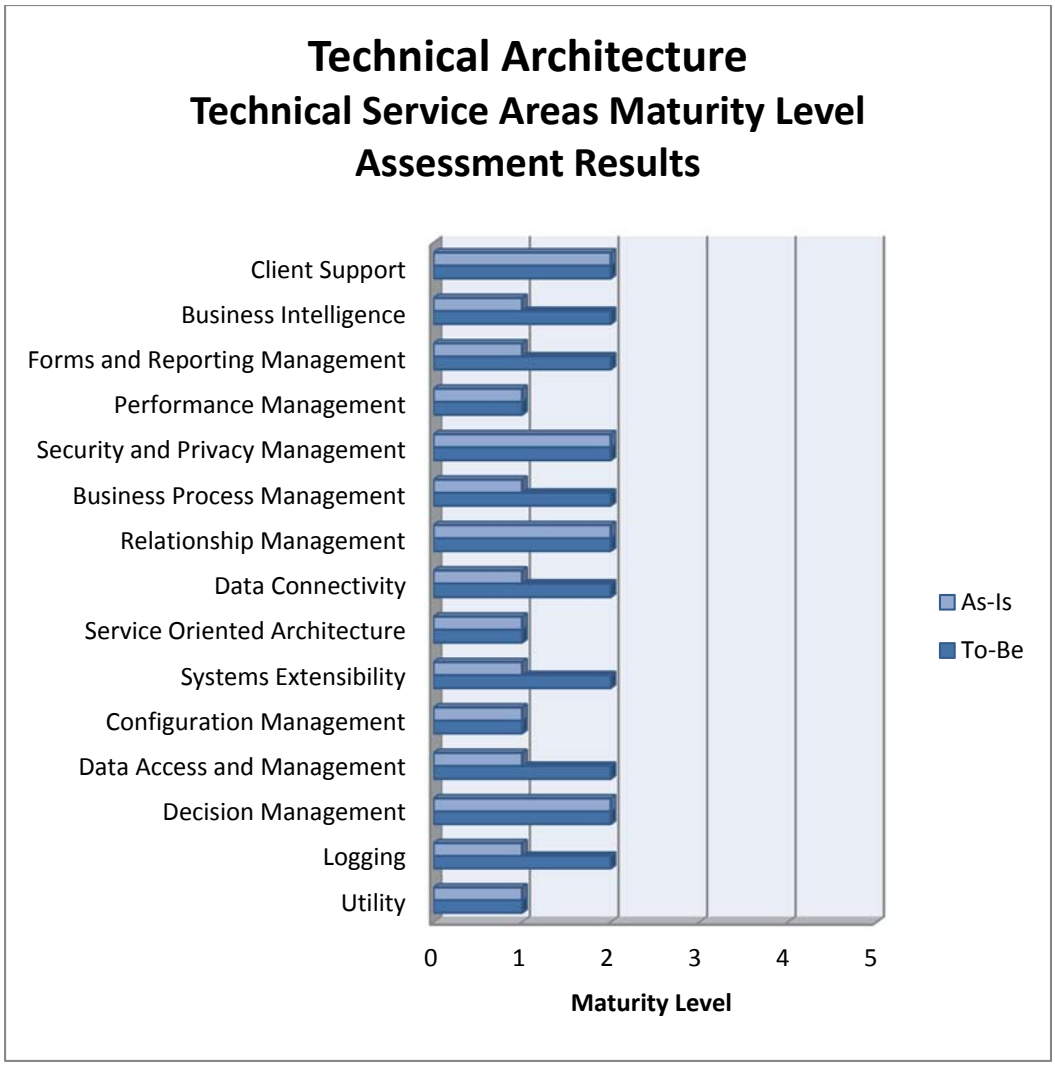


Figure 3 - Technical Architecture Technical Service Areas Maturity Level Assessment Results

To improve Nebraska Medicaid's IT systems and technology, IS&T will be an active participant in implementing the State-identified transition projects listed in the MITA Roadmap. Through the execution of these projects, MITA maturity levels will increase, move the State Medicaid Enterprise forward, and evolve Medicaid's TA.

During the MITA Roadmap implementation, IS&T will continue to collaborate with MLTC team members to validate and expand on business needs and their priorities. According to their relative importance to the Division, these MITA Roadmap technical opportunities will be reflected in the developing strategy that Nebraska will use to modernize its Medicaid programs and systems.

1.7. Seven Standards and Conditions Summary

In the MITA 3.0 Framework, the Seven Standards and Conditions (SSC) are comprised of the conditions in Table 2. Nebraska's SSC are, for the most part, at a Level 1 MITA maturity and will progress to a Level 2 maturity.

Nebraska is committed to implementing several projects within the next six years that will transform its operations, increase MITA maturity, and improve business capabilities. Table 2 highlights the major current/planned projects and the SSC on which they will have measurable impact. Section 5 of this document discusses these relationships in greater detail.

	Currently Underway			Planned			
SSC Condition	MMIS Replacement	EES	PS&E System	Enterprise Data Management Strategy	SOPs	Performance Measurement	Enterprise Workflow Management Strategy
Modularity	X	X	X	X	X		X
MITA Condition	X	X	X	X	X	X	X
Industry Standards	X	X	X	X		X	
Leverage	X	X	X	X	X		X
Business Results	X	X	X	X	X	X	X
Reporting	X	X	X	X		X	X
Interoperability	X	X	X	X		X	X

Table 2 - SSC and Supporting Projects

1.8. Major Themes from Assessment

Throughout the SS-A, the project team worked with Nebraska DHHS SMEs to gather the necessary information to complete the assessments. While the staff are working diligently, the organization could be working more efficiently through documented/ standardized processes supported by automation and a unified data management and reporting strategy. In addition, the organization could be working more effectively by implementing additional performance measures and addressing areas/issues that do not meet designated performance standards. In some cases, achieving higher levels of process maturity may require reaching out to, and coordinating with, other state agencies in order to increase data sharing and process efficiencies. Best practices should also be sought from other SMAs and CMS and incorporated as appropriate for Nebraska.

A second major theme is that some areas of the organization are more mature in their processes than others. For example, while some areas use a significant amount of automation, e.g., Eligibility, other areas still rely heavily on paper-based processes, e.g., Contract Management.

This theme results in an approach that is not a “one size fits all” but must consider the overall goals and objectives of MLTC when addressing areas at the lower levels of MITA maturity.

1.9. Gap Analysis

As described in greater detail in Section 6 of this document, the project team determined common gaps across one or more business processes. These gaps and the primary solutions are:

- Outdated and/or limited documentation of business processes
- Lack of uniform data management standards and practices
- Limited performance measures, including stakeholder satisfaction, for most business processes
- Lack of standardized process capability/coordination
- Legacy systems with limited flexibility to keep pace with changes in technology, legislation, and regulations
- Limited ability to interface with other systems

1.10. Nebraska MITA 3.0 Roadmap Summary

The Nebraska MITA 3.0 Roadmap defines the planned projects that are either currently in process or will be initiated in the next six years. A six-year timeline was chosen to accommodate the planned MMIS replacement project.

The projects described in the MITA Roadmap should enable the SMA to achieve desired To-Be maturity levels in all three architectures. Additional details on each project, including schedule, budget, project goals, and management plan, are provided in Section 7 of this document.

As with any environment, changes can occur and this Roadmap will likely be revised over time. Nebraska’s MITA Roadmap could change as a result of funding constraints, resource availability, updates to the MITA framework, or changing State and federal requirements.

Figure 4 - Nebraska MITA 3.0 Roadmap 2014-2020Figure 4 provides a summary level view of the Nebraska MITA Roadmap. Bolded dates indicate estimated or to be determined (TBD) dates.

ID	Task Name	Start	Finish
1	Administrative Simplification (AS-Eligibility Claim Status)	09/03/2012	01/30/2015
2	Administrative Simplification (AS-Electronic Funds Transfer, Electronic Remittance Advice)	04/01/2013	11/28/2014
3	Balanced Incentive Program	05/01/2014	09/30/2015
4	CMS Quarterly Reports	12/02/2013	***12/31/2015***
5	Eligibility and Enrollment System	07/01/2014	04/29/2016
	Electronic Health Records Incentive Payment Program	09/03/2012	05/05/2022
7	Health Information Exchange	07/01/2013	***12/28/2018***
8	ICD-10	09/03/2012	06/30/2016
9	Managed Long-Term Serivces and Supports	07/01/2014	***12/30/2016***
10	MMIS Replacement	07/01/2014	***07/01/2014***
11	Provider Screening and Enrollment	09/03/2012	06/30/2015
12	Transformed-Medicaid Statistical Information System	01/01/2013	03/31/2015
13	MITA Transformation	***01/01/2015***	***12/31/2020***
14	Enterprise Data Management Strategy	***01/01/2015***	***01/01/2015***
15	Enterprise Business Intelligence and Analytics Strategy	**01/01/2015**	**01/01/2015**
16	Enterprise Workflow Management Strategy	**01/01/2016**	**01/01/2016**
17	Performance Measures - Planning and Implementation	**07/01/2015**	***07/01/2015***
18	Standard Operating Procedures - Development and Implementation	**01/01/2015**	***01/01/2015***
19	**RFP-Related Initiatives**	**07/01/2014**	**07/31/2018**
20	EES Track RFP Start Date	07/01/2014	07/01/2014
21	MLTSS Contract Award	12/31/2014	12/31/2014
22	Physical Contract Base	06/30/2015	06/30/2015
23	MMIS RFP Release	11/30/2015	11/30/2015
24	Actuarial (PH/BH) Base	03/31/2016	03/31/2016
25	DSH/UPL Base Term	06/30/2016	06/30/2016
26	Actuarial (LTSS) Base	08/31/2016	08/31/2016
27	Behavioral Contract Base	08/31/2016	08/31/2016
28	Enroll Broker Base	09/30/2016	09/30/2016
29	EQRO Base	09/30/2016	09/30/2016
30	Telligen UM Base Term	12/30/2016	12/30/2016
31	DUR Base Term	12/30/2016	12/30/2016
32	POS Base Term	12/30/2016	12/30/2016
33	DSS Base Term	07/31/2018	07/31/2018

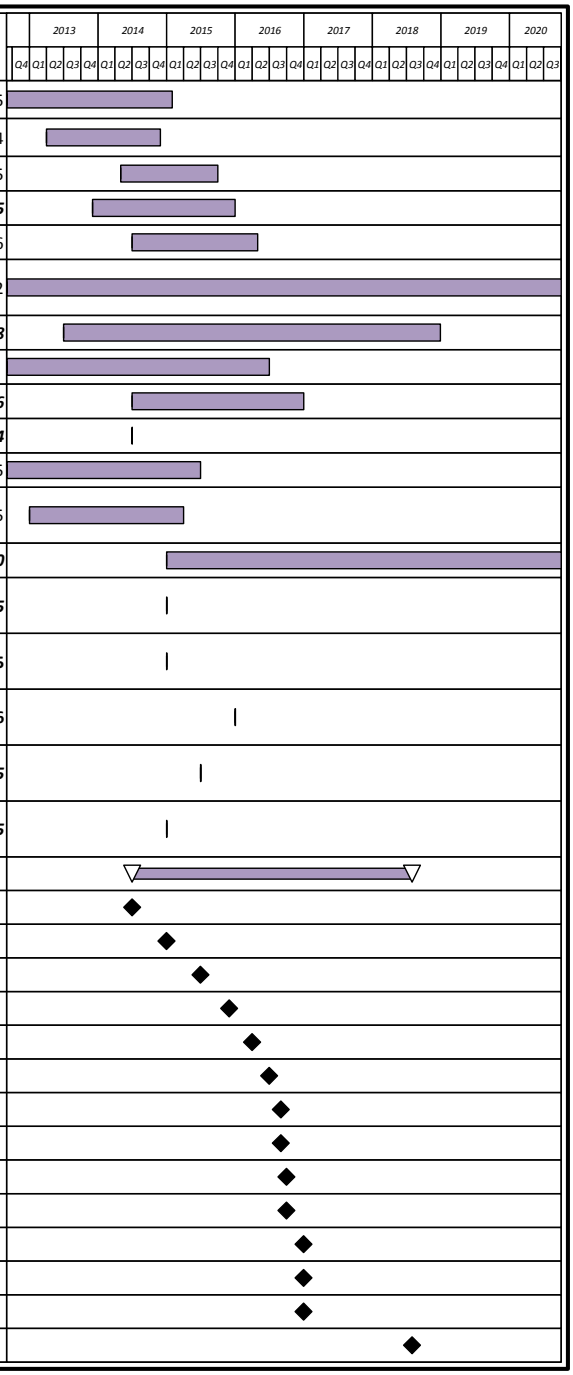


Figure 4 - Nebraska MITA 3.0 Roadmap 2014-2020

1.11. Key Next Steps

MLTC sees this document, and the projects presented herein, as an opportunity for business transformation. Steps have been taken to increase collaboration both internally and with other entities to successfully achieve this transformation. Nebraska will utilize the information and recommendations contained in the SS-A, particularly in the MITA Roadmap, and continue to build upon MLTC's commitment to effectiveness and efficiency in order to achieve the desired To-Be state. This can be done by collaborating with its partners and continuing to implement existing/planned projects listed in the MITA Roadmap.

In addition, Nebraska will maintain/monitor the SS-A and the MITA Roadmap on a continuing basis in order to maintain its aggressive schedule, ensure progress, and allow for incorporation of changes and updates. This document is intended to be a stepping stone to achieve greater MITA maturity and business transformation.

2. Introduction

2.1. Background

MLTC and IS&T prepared this comprehensive business, information, and technical process assessment using the MITA framework. This assessment begins with the State's 2.0 SS-A dated March 2012 and expands/updates it, utilizing the MITA Framework 3.0.

CMS requires that a SS-A be completed prior to approval of FFP for enhancements to or the replacement of a MMIS, as well as Medicaid Information Technology (IT) system(s) projects related to eligibility determination and enrollment activities. This document assesses how well the State's Medicaid EA meets current and anticipated business imperatives and evaluates relevant strengths, opportunities for improvement, and risks. Included is a MITA Roadmap that clearly identifies the initiatives and projects that are improving Nebraska's MITA maturity levels.

The goal of this assessment process is to make smart, informed decisions about how to bring future business, information, and technical architectures to higher levels of MITA maturity, thereby improving the responsiveness, nimbleness, and cost-effectiveness of Nebraska's Medicaid program. In conformance with MITA 3.0 guidelines, this SS-A includes five critical project phases:

- Define MITA 3.0 project approach
- Establish project structure
- Perform MITA assessment activities
- Complete MLTC Roadmap
- Produce SS-A

MLTC will utilize and leverage the findings contained in this document to support its next steps toward Medicaid modernization, which will include, but are not limited to:

- Identification and validation of business needs/processes that will assist in the development of MMIS requirements.
- Development of associated Advanced Planning Documents (APDs) and Requests For Proposals (RFPs)
- Incorporation of the SSC into its future technology investments
- Modification of MLTC business practices to align with the MITA business model

2.2. Overview of Nebraska Medicaid Enterprise

As the CMS-recognized SMA, MLTC is primarily responsible for administration of the Medicaid program in Nebraska. It is part of DHHS, which also houses the following divisions:

- Division of Behavioral Health
- Division of Children and Family Services
- Division of Developmental Disabilities
- Division of Public Health
- Division of Veterans' Homes

Certain Medicaid-related functions are delegated to other divisions within DHHS. For example, the Division of Developmental Disabilities administers the Adult Day and Adult Comprehensive Waivers and the Home and Community Based Services (HCBS) Waiver for Children.

A significant portion of Medicaid operations and systems, such as the MMIS and Nebraska's eligibility system (N-FOCUS), are managed by MLTC staff, augmented by central support units within DHHS including:

- Communications and Legislative Services – Responsible for legislative planning and support, outreach planning, media relations, and all aspects of communication
- Information Systems and Technology – Provides leadership, planning, implementation, and support services for all of the Department's IT needs
- Legal Services – Responsible for all of the Department's legal activities
- Operations – Responsible for DHHS' financial services, human resources and development, internal audit, and other support services

In addition, MLTC contracts with external entities to perform specific services; these contracts include, but are not limited to, enrollment assistance (Medicaid Enrollment Center), prior authorization for certain services (Telligen), and pharmacy claims processing (Magellan Health Services).

2.3. Project Scope and Approach

2.3.1. MITA Initiative

MITA is a business-centric initiative designed to stimulate an integrated business and IT transformation within Medicaid agencies. MITA can improve Medicaid program administration by aligning business processes and supporting technology not only with national guidelines, but also within a state's Medicaid enterprise. It is intended to provide states with an information architecture they can use as a framework for improving the Nebraska Medicaid program and exchanging data with members, vendors and service providers, state Medicaid agencies, CMS, and other agencies and programs that are supported by Federal matching funds.

MITA requires standards that allow interoperability across different platforms, application integration, and modular programming to leverage information assets and introduce changes incrementally. It also envisions technical and business processing changes, including:

- Improvements in program monitoring and the quality of care through data sharing
- Efficient use of resources through the sharing of reusable software, hardware, and data
- Timely responses to program changes and emerging health needs
- Improvements in access to high quality information for clients and providers to enable more informed health care decisions

This transformation is profound because of its scope and the fact that some required technologies have not yet evolved in the industry. Certain changes to business processes can be made in two to three years, but others will take place over the next five to ten year strategic planning arc under discussion at MLTC.

In addition to being a template that SMAs can use to develop their EAs, MITA 3.0 is also an evaluation framework provided by CMS for states to self-assess their Medicaid processes. The SS-A will:

- Provide a structured method for documenting and analyzing a state's current Medicaid business enterprise
- Align Medicaid business areas to MITA business areas and business processes
- Enable the SMA to use defined levels of business maturity to help shape the future vision of its Medicaid enterprise
- Provide the foundation for a gap analysis that will support the state's transition planning
- Facilitate preparation and implementation of the MITA Roadmap
- Focus the APD to reflect current project funding requests and identify what is achievable

While the MITA Roadmap is a good baseline for supporting innovation and progress, it will be periodically reviewed and updated to account for changes in program priorities, new state and federal laws, and technology changes/advances.

2.3.2. MLTC's Approach

MLTC chose to adopt a strategy for completing the MITA 3.0 SS-A that relies on the Division's current environment. To determine the appropriate scope and approach, the following factors were considered:

- In addition to the daily administration of the Medicaid program, Department staff are completing tasks related to multiple projects, including:
    - Implementation of a new eligibility and enrollment solution (EES)

  - Acquisition of a new provider screening and enrollment (PS&E) system
  - ICD-10 implementation
  - Implementation of changes mandated by the Affordable Care Act
  - Administrative simplification (AS)
  - MMIS replacement planning
- MLTC's decision to proceed with the development of a new EES and MMIS will facilitate an increased maturity in the To-Be assessment and the activities described in the MITA Roadmap.
- Some business processes contained in the MITA framework are not under the control of MLTC. For instance, all state departments in Nebraska utilize a central financial system, Enterprise One.

Based on the above factors, the BA As-Is portion of this assessment was completed by starting with the information contained in the 2.0 SS-A, cross-walking the MITA 2.0 business areas/processes to MITA 3.0 business areas/processes, making appropriate updates, rearranging the information in conformance with the 3.0 Framework, and adding additional content required by new or changed business area processes found in MITA 3.0. Because Information and Technical Architecture were not fully defined in MITA 2.0, these areas required additional effort to assess and document the As-Is. The MITA Roadmap and To-Be assessment were created in an iterative process, because of their inter-relationship. Further, for this SS-A, MLTC focused its efforts on the business processes within its control and ability to affect change.

Over 50 stakeholders and subject matter experts (SMEs) within MLTC and the Department participated in the MITA 3.0 SS-A. They were selected for this effort based on their knowledge of a specific business process or system.

2.3.3. Business Assessment Process

When conducting the business assessment for the MITA 3.0 SS-A, the team leveraged the MITA 2.0 SS-A report and artifacts and met with MLTC business experts. Figure 5 - As-Is Business Assessment ProcessFigure 5 illustrates the process that was followed to document the As-Is for each MITA business process.

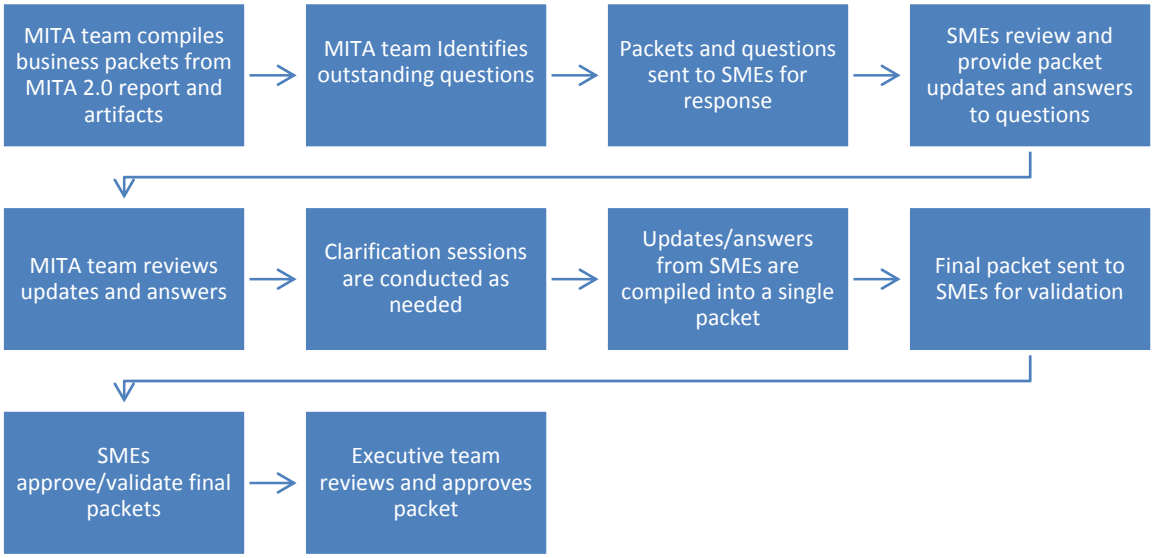


Figure 5 - As-Is Business Assessment Process

Based on the information gathered in the As-Is assessment process, MITA maturity levels were determined for each business process. In the assessment of To-Be maturity levels, the impacts of existing or planned projects (EES and MMIS, for example) were considered.

2.3.4. Information Architecture Assessment Process

When conducting the Information Architecture (IA) assessment for the MITA 3.0 SS-A, because the IA was not as fully defined in MITA 2.0 as in MITA 3.0, the team did not have as much information to leverage from the MITA 2.0 SS-A report. As a result, the team had to gather and develop the information by looking through repositories and meeting with MLTC and IS&T resources. In addition, the IA required more interaction between MLTC and IS&T, so the following figure uses a swim lane flowchart format to better illustrate these interactions. Figure 6 illustrates the process that was followed to document the As-Is for each IA component:

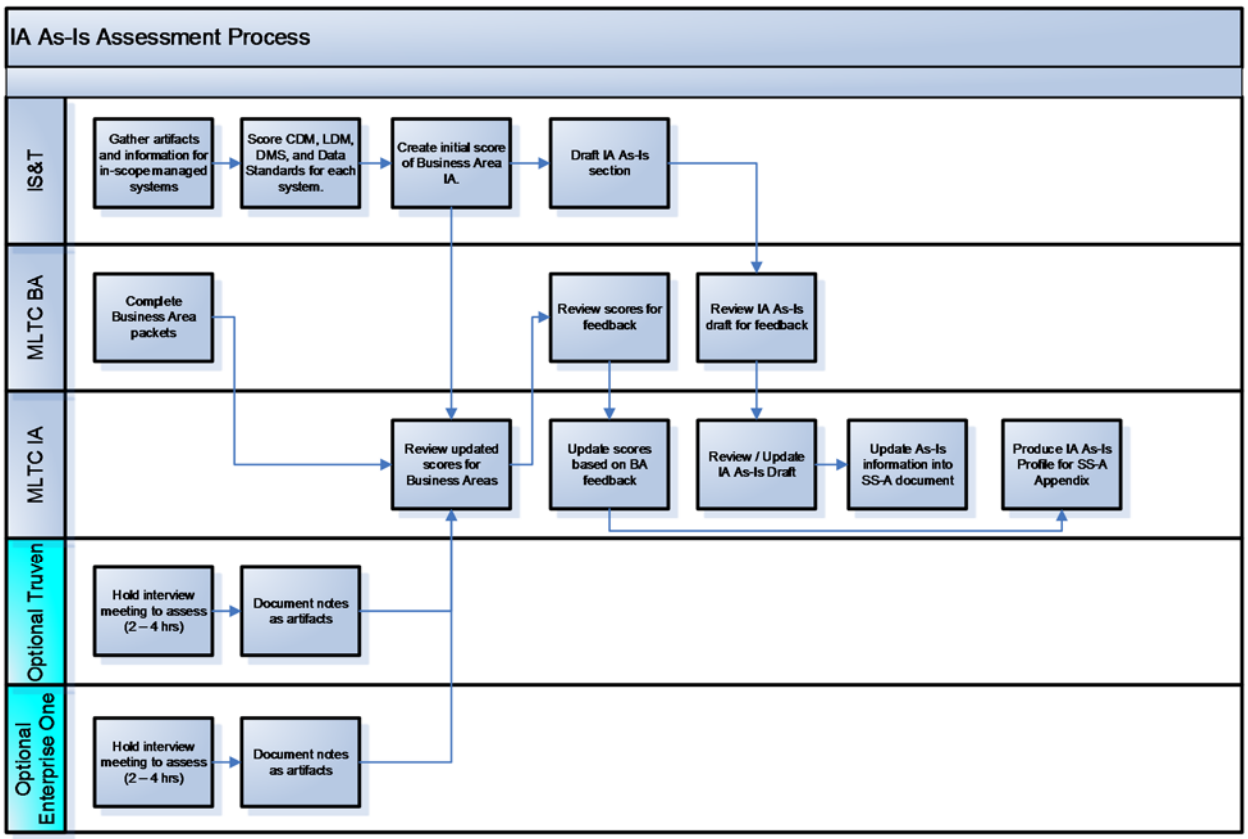


Figure 6 - IA As-Is Assessment Process

Similar to the Business Architecture (BA), As-Is MITA maturity levels were determined for each component and assessment of To-Be maturity levels considered the impacts of existing or planned projects (EES and MMIS, for example).

2.3.5. Technical Architecture Assessment Process

When conducting the Technical Architecture (TA) assessment for the MITA 3.0 SS-A, because the TA was not as fully defined in MITA 2.0 as in MITA 3.0, there was little information to leverage from the MITA 2.0 SS-A report. The team gathered and developed the information by looking through repositories and meeting with IS&T resources.

2.3.6. Assessment Limitations

The information contained within this document is limited based on certain factors, including:

- There are several MITA business processes in which the current Medicaid Enterprise (MLTC and IS&T) has no oversight or management authority. For example, the Manage Registry process belongs to Public Health and covers 11 sub-processes, one for each of the 11 registries. MLTC requires information from these Registries for reporting purposes, but accessing the required data has been challenging because there is no standard agreement for interagency data sharing. With implementation of the T-MSIS

project, MLTC anticipates future data sharing with Public Health, thus increasing the MITA maturity scores for access, timeliness, accuracy, cost effectiveness, and stakeholder satisfaction.

- CMS has not released guidance for the Member Management business area. As a result, maturity levels for these four business processes were not scored.

2.4. Document Overview

The balance of this document is organized into six sections, as follows:

- Section 3 – Business Architecture Assessment: Presents the results of the BA assessment for the ten business areas at a business process level. This includes the As-Is (current), the To-Be (future), and maturity assessments for all ten business areas and the 80 business processes.
- Section 4 – Information and Technical Architecture Assessment: Presents the results of the As-Is IA and TA assessment for the systems supporting the enterprise, as well as maturity assessments for the 15 technical functions and the seven information capabilities.
- Section 5 – Seven Standards and Conditions: Presents the business, technical, and information recommendations structured around the CMS SSC.
- Section 6 – MITA Gap Analysis: Presents a discussion of the gaps between the As-Is and the To-Be maturity for each MITA business area and recommendations to bridge the gaps.
- Section 7 – MITA 3.0 Roadmap: Presents Nebraska's MITA 3.0 Roadmap following the CMS requirements.
- Section 8 – Conclusion: Provides a summary of the Assessment's key findings, conclusions, and next steps.

Following Section 8, several appendices are included to provide additional background and supporting information.

3. MITA SS-A Business Assessment Results

3.1. Introduction

As illustrated in Figure 1 and described in Section 2, the MITA 3.0 project team used MITA 2.0 artifacts as the foundation for developing this SS-A, particularly the As-Is evaluation. For each of the ten MITA 3.0 business areas and corresponding 80 business processes, the project team created SME packets. The SME packets were in template form, and included the relevant MITA 2.0 material (notes, process flows, etc.) and the CMS MITA 3.0 business process descriptions for reference. The packets were distributed to the identified SMEs for review and updating. Upon return of the updated packets, the templates for each process were updated/consolidated to reflect the input of multiple SMEs. To ensure accuracy, these templates were sent back to the appropriate SMEs for approval. Due to the complexity of some Medicaid business processes, meetings with SMEs at various points through the information collection process were necessary; however, the project team tried to minimize work disruption as much as possible.

ReadyCert, a web-based application that helps states complete some of the SS-A processes, was used for maturity level scoring and maintenance of the final versions of the approved business process templates. All versions of the documents were saved to MLTC's MITA 3.0 SS-A SharePoint repository but only the final approved business process templates were uploaded to ReadyCert as formal artifacts for this SS-A.

3.2. Scoring Results

Final scoring of each business area was completed after the approved business process templates were loaded to ReadyCert. The MITA maturity level for a particular business area can only be as high as the lowest maturity level of the business area processes. Any business processes that either were not applicable or simply do not exist were scored a zero; however, any zero scores were not applied to the overall business area maturity level. The As-Is maturity level results for each business area are contained in Table 3. The table provides the number of business processes for each area and summarizes their maturity. This distinction is important because it provides a sense of the effort necessary to elevate a business area to the next level of MITA maturity.

Business Area	Not Applicable	Maturity Level 1	Maturity Level 2	Maturity Level 3	Maturity Level 4	Maturity Level 5
Business Relationship Management **Business Processes: 4** **BA Overall: Level 1**			4			
Care Management **Business Processes: 9** **BA Overall: Level 1**			8	1		
Contractor Management **Business Processes: 9** **BA Overall: Level 1**			9			
Eligibility & Enrollment Management **Business Processes: 8** **BA Overall: Level 1**			6	2		
Financial Management **Business Processes: 19** **BA Overall: Level 1**			14	5		
Member Management * **Business Processes: 4** **BA Overall: N/A**		4				
Operations Management **Business Processes: 9** **BA Overall: Level 1**			7	2		
Performance Management **Business Processes: 5** **BA Overall: Level 1**			5			
Plan Management **Business Processes: 8** **BA Overall: Level 1**			8			
Provider Management **Business Processes: 5** **BA Overall: Level 1**			5			

Table 3 - As-Is Maturity Level by Business Area

***NOTE**: The Member Management business area has not been finalized by CMS, and as a result, scoring is provisional and will be completed once the business processes are finalized.

The Nebraska MITA 3.0 BA As-Is assessment demonstrated improvement in a number of business areas. Unfortunately, a direct comparison between MITA 2.0 and 3.0 business areas and processes cannot be made. While MITA 3.0 only added one business process (increased from 79 to 80 processes), the mix and distribution of processes moved among the business areas. MITA 3.0 also added two additional business areas (up to 10 from 8) and two business areas originally in MITA 2.0 (Program Management and Program Integrity) were eliminated and integrated into other areas of MITA 3.0. Finally, the questions in the CMS MITA 3.0 Framework utilized for scoring were, in many cases, different and more detailed than what was contained in MITA 2.0. Due to the additional detail contained in some questions, a business process scored at a maturity level of 2 in MITA 2.0 may have been reduced to a maturity level of 1 in MITA 3.0.

While direct business area comparisons between MITA 2.0 and 3.0 are invalid, conclusions can still be drawn about the overall maturity of the Nebraska Medicaid enterprise. Nebraska's MITA 2.0 SS-A scored 72 of the 79 (91%) business processes at maturity level 1. Only six business processes in MITA 2.0 were scored at maturity level 2, with one not applicable. The MITA 3.0 assessment scored 66 of 80 business processes (82.5%) at MITA maturity level 1 and 10 (12.5%) at maturity level 2. At the time of this report, four business processes were considered not applicable because CMS had not finalized the Member Management business area. Comparing the MITA 2.0 and 3.0 assessments indicates that Nebraska has improved MITA maturity since the completion of the MITA 2.0 SS-A. Table 4 presents the To-Be summary maturity level for each business area. For this assessment, a six-year timespan is used, because it represents the estimated timeline for completion of the MMIS replacement project.

Business Area	Not Applicable	Maturity Level 1	Maturity Level 2	Maturity Level 3	Maturity Level 4	Maturity Level 5
Business Relationship Management **Business Processes: 4** **BA Overall: Level 2**				4		
Care Management **Business Processes: 9** **BA Overall: Level 2**				5	4	
Contractor Management **Business Processes: 9** **BA Overall: Level 2**				9		
Eligibility & Enrollment Management **Business Processes: 8** **BA Overall: Level 2**				4	4	
Financial Management **Business Processes: 19** **BA Overall: Level 2**				17	2	
Member Management * **Business Processes: 4** **BA Overall: N/A**		4				
Operations Management **Business Processes: 9** **BA Overall: Level 2**				5	4	
Performance Management **Business Processes: 5** **BA Overall: Level 2**				5		
Plan Management **Business Processes: 8** **BA Overall: Level 2**				5	3	
Provider Management **Business Processes: 5** **BA Overall: Level 2**				5		

Table 4 - To-Be Summary Maturity Level by Business Area

Table 5 provides a summary level comparison of business process maturity from the As-Is to the To-Be:

3.0 Assessment	Maturity Level 1	Maturity Level 2	Maturity Level 3
As-Is	66 (82.5%)	10 (12.5%)	0 (0%)
To-Be	0 (0.0%)	59 (73.8%)	17 (21.3%)

Table 5 - MITA 3.0 As-Is vs. To-Be Summary Maturity Level Comparison

Because the four Member Management business processes are considered not applicable, they are not included in the maturity level counts or percentages in Table 5.

For the balance of this section, each business area is discussed in more detail. MLTC's strengths and the opportunities for improvement are also described that could enable Nebraska to realize additional MITA maturity. These opportunities for improvement were identified through the As-Is information collection process, including responses from MLTC SMEs, Medicaid best practices, and guidance from the MITA 3.0 Framework. They will produce measurable improvements in MITA maturity, are consistent with MLTC's goals and objectives, can be considered critical for process improvement or risk mitigation, and are feasible. It should be noted that the listed opportunities are not an all-inclusive list; they are examples/suggestions meant to convey the possible improvements to MITA maturities within each business area. The MITA Roadmap is the repository for projects and initiatives that will lead Nebraska to the desired To-Be states for each business area.

Through collaboration, discussion and analysis, the following recommendations were developed to achieve overall To-Be maturity levels. They apply to all ten business areas:

- Focus enterprise-wide on standardization, documentation, and automation of business processes
- Develop performance and stakeholder satisfaction measures
- Design a unified data management and reporting strategy

One project, MITA transformation, includes a number of smaller projects or initiatives that cover all business areas. When this project is mentioned, it refers to one of the projects/initiatives included in it.

3.3. Business Assessment Findings

3.3.1. Business Relationship Management

3.3.1.1. Overview

The Business Relationship Management (BR) business area is a collection of business processes that facilitate the initiation and management of relationships between MLTC and its business partners, including but not limited to, providers, managed care organizations (MCOs) and CMS. Its scope includes dissemination of information from stakeholders such as MMIS staff, CMS, coordination of benefits agreement representatives, State agency technology consultants, and other State Medicaid personnel to business partners. This business area also receives and processes inquiries from providers, trading partners, clearinghouses, MCOs, and others.

Additionally, BR defines the exchange of information and trading partner agreements (TPA) between the SMA and intrastate, interstate, and federal agencies. These agreements may address such concerns as interoperability functionality, establishment of inter-agency service level agreements (SLA), identification of the types of information exchanged, and security and privacy requirements.

The BR business area is comprised of the following business processes:

- BR01 – Establish BR
- BR02 – Manage BR communication
- BR03 – Manage BR information
- BR04 – Terminate BR

3.3.1.2. Business Relationship Management – As-Is Summary

MLTC currently establishes business relationships with other governmental departments and trading partners. TPAs are established when data will be supplied or received by MLTC. Memoranda of understanding (MOU) are utilized to formalize a non-financial business relationship with other state departments. Interagency agreements are utilized by MLTC to formalize an agreement with another State department that generally involves some form of payment for services by MLTC. Contractors also have a business relationship with the SMA. Table 6 lists the types of agreements, and examples of business entities and business areas responsible for business relationship agreements.

Agreement Type	Example(s)	Relevant Business Area
TPAs	Clearinghouses	BR – Legal Services
SLAs	MCOs	BR – Support Services
MOU	Other state agencies	BR – Legal Services
Electronic data interchange (EDI) agreements	Providers, MCOs	BR – Provider Management, Physical Health and Behavioral Health MCOs
Business associate agreements	Health information exchange (HIE) organizations	BR – Legal Services
Business contracts, contracts for services, contracts resulting from RFPs	MCOs, consultants, operations partners, enrollment brokers	Contractor Management – Legal Services, Support Services, Eligibility and Initiatives, Department of Administrative Services (DAS) (above a standard dollar threshold)
Provider agreements	Providers	Provider Management – Legal Services
Purchase orders	Purchase of equipment, supplies	BR – Support Services

Table 6 - Agreement Types and Impacted Business Areas

Information exchange methods with business partners include email, mail, bulletins available on the Division's website, facsimile, telephone, or EDI. Types of communication include notifications, correspondence, communication plans, etc. Most of the activities associated with acquisition and management of documents is primarily manual.

MLTC complies with Health Insurance Portability and Accountability Act (HIPAA) agreement requirements and exchanges limited information with business partners through EDI. Standardized forms and other contract management documentation are available to staff through a dedicated intranet portal. Otherwise, management and tracking is manually intensive as no system exists to track expiration dates, formal communications, renewals, or amendments.

Strengths

- There is a repository of forms used in this process that is available and maintained on the MLTC SharePoint site.
- DHHS staff members perform their business relationship duties successfully without the benefit of contemporary automation.

Opportunities for Improvement

- Tracking of process steps and results is difficult and does not provide sufficient transparency into this business area.
- Tracking and management functions are distributed across different departments; this impedes the ability to focus on managing overall program policy and expenditures.
- While there has been internal adoption of standard data exchange and automation agreements, the SMA is challenged with extending these standards and practices to business partners.
- There is no automation of interagency agreement initiation and management, limiting opportunities for improvement of interoperability and business results. Improvements in security and timeliness of data exchange are limited due to the lack of business associate agreements with other states regarding patient encounters with out-of-state providers.

3.3.1.3. Maturity Level Profile

Figure 7 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the business process with the lowest maturity level. As illustrated, the As-Is MITA maturity level for this business area is Level 1, and the six-year To-Be MITA maturity level goal is Level 2.

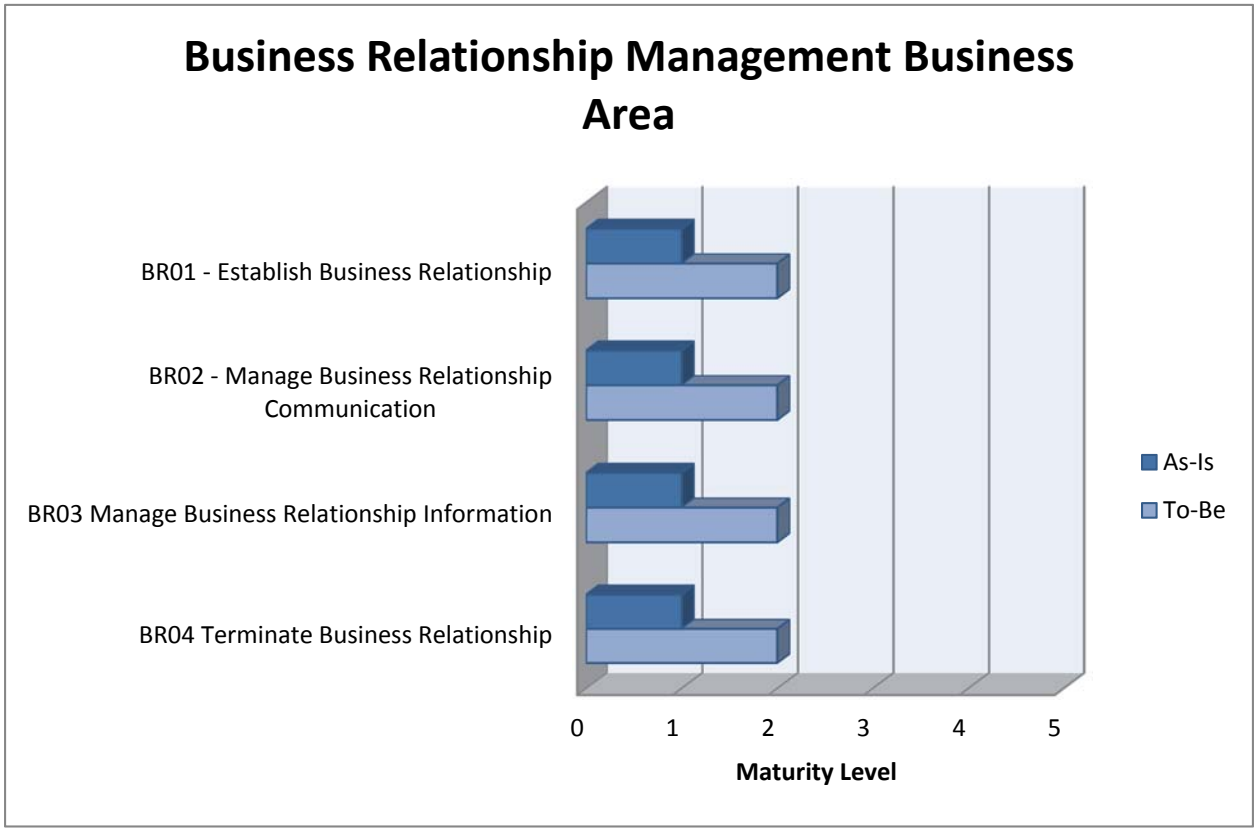


Figure 7 - Business Relationship Management Maturity Levels

3.3.1.4. Business Relationship Management – To-Be Summary

The project team facilitated three sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for BR. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

Throughout the analysis, the team identified new or existing efforts that will enable the SMA to progress to its identified maturity levels. The following projects and initiatives appear on the MITA Roadmap and will improve the BR maturity level.

High Impact on Business Area Processes and Maturity Levels:

- MMIS Replacement (existing project)
  - Replacement of MLTC's MMIS will affect the Division's management of its business relationships with its trading partners. MLTC expects that this project will automate what are currently manual processes with its trading partners and improve timeliness, cost effectiveness, and data accuracy of these interactions. This project will also further the standardization of electronic communications with trading partners and MLTC's stakeholders.

  - MMIS functions will contribute to more efficient management of information related to providers and MCOs.
  - It is anticipated that Developmental Disability Waiver claims will move from N-Focus to MMIS, and thus eliminate one claims system.
- Enterprise Workflow Management Strategy (newly identified project)
  - MLTC is currently engaged in a number of large implementation projects which will impact all ten business areas. Some projects (e.g., EES, MMIS Replacement) will include workflow management components. This presents an opportunity to leverage these workflow components and create a unified/integrated set of workflow management business rules. Use of these rules will contribute to improved process performance by decreasing manual coordination between departments and units within the SMA enterprise. They will promote improvement for all six MITA business qualities, particularly timeliness, cost effectiveness, efficiency, data access, and stakeholder satisfaction.
  - As part of this strategy, MLTC will determine the capabilities of its OnBase document and workflow management application to employ or integrate with a standard business rule set for workflow management.
  - Business Relationship Management and Contract Management business areas can benefit through improved coordination of action across the lifecycle of business agreements from solicitation through expiration.
- MITA Transformation – Business Agreement Management Strategy (newly identified project)
  - MLTC plans to develop a repository of business agreements that integrates with and leverages the capabilities of the Enterprise Data Management Strategy. Types of business agreements include MOUs, TPAs, SLAs, EDI agreements, business associate agreements, and business and service contracts.
  - This repository will make available all information required to support the Business Relationship and Contractor Management business areas. It will be capable of providing data filtered or sorted by such criteria as business unit, contract status, contract manager, vendor status, start date, end date, renewal date, type of contract, buyer name, and vendor name.
  - Implementation of this repository should result in increased timeliness, data access, accuracy, cost effectiveness, efficiency, and usefulness to stakeholders.

Medium Impact on Business Area Processes and Maturity Levels:

- AS-Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) (existing project)

  - This initiative will improve the standardization of electronic communication between MLTC and its trading partners. However, it will not increase maturity level as it only represents the 835 EDI transactions.
- AS-Eligibility Claim Status (ECS) (existing project)
  - This initiative will also improve the standardization of electronic communication between MLTC and its trading partners. However, it will not increase maturity level as it only represents the 270/271 EDI transactions. It will contribute to process timeliness.

For the detailed gap analysis for this business area, please reference Section 6.2.

3.3.2. Care Management

3.3.2.1. Overview

The Care Management (CM) business area consists of nine business processes, including activities such as disease management, national health registries, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, case management, authorizations, and referrals. These activities support overall SMA care management and population management objectives. The business processes have the common purpose of collecting information about the needs of individual clients, creating treatment plans with targeted outcomes, and managing client's health status.

The CM business area is comprised of the following business processes:

- CM01 – Establish case
- CM02 – Manage case information
- CM03 – Manage population health outreach
- CM04 – Manage registry
- CM05 – Perform screening assessment
- CM06 – Manage treatment plan and outcomes
- CM07 – Authorize referral
- CM08 – Authorize services
- CM09 – Authorize treatment plan

3.3.2.2. Care Management – As-Is Summary

CM activities within the Nebraska Medicaid enterprise are not performed using standard processes and systems. The disparateness of systems across the Medicaid enterprise impedes care management and requires major effort and staff resources to process and analyze clinical

data. The current data warehouse is also limited in its ability to store and process/validate data from multiple systems.

For MITA purposes, CM is a mix of manual and automated information processes used to monitor compliance thresholds established by state and federal standards, professional standards of care and program business rules.

MLTC uses prior authorization and treatment plan definitions interchangeably. The Division does not have a referral process as defined by MITA. Referrals are only required for those clients who are enrolled in the Lock-In program. The referral process has been streamlined to the point where no official referral document is required from either the Lock-In provider or the referred to provider. Only the Lock-In provider's number is required on the claim being submitted by the referred to provider. MLTC outsources the manage treatment plan and outcomes process to the contracted MCOs; they are responsible for performing these activities for targeted populations.

Currently, MLTC performs a limited quality review of the MCOs' CM activities to ensure that quality care is being provided. The process of developing a more standardized and robust MCO quality review process has begun.

Authorizations reside in the MMIS system but are also housed in N-FOCUS (eligibility system), CONNECT (case management tracking), and KODAK (prior authorization system that is being eliminated). Depending on the authorized service, the authorization/treatment plan may be entered into N-FOCUS, CONNECT, or KODAK, then re-entered into MMIS for processing. An example of this process is service treatment plans for assisted living. Local coordinators create treatment plans in CONNECT that are sent to the data entry staff to be re-entered into MMIS. Because of this, not all service authorization data is systematically available for MMIS editing during claims processing and entry errors occur. For those authorized services not entered into MMIS, it is labor intensive to research and identify authorizations within other systems needed for processing claims. This approach prevents the automation of adjudicating against all authorizations during claims processing because MMIS only adjudicates using the authorizations contained within MMIS.

Proprietary authorization forms are used by providers to submit requests either via fax or mail. The MMIS is capable of receiving HIPAA compliant EDI 278 transactions but to date no provider is submitting authorization requests electronically.

There is no automated workflow to manage and distribute files and alert staff of actions needed to coordinate and authorize services for clients. There is also no centralized reporting system to sufficiently support CM analytics and quality reporting across programs due to the various systems used during the process.

For CM, MLTC does not perform stakeholder satisfaction activities. While some population outreach is performed, the lack of data needed to identify specific clients receiving CM from multiple agencies results in a limited population outreach process.

Strengths

- MLTC is capable of accepting HIPAA compliant EDI 278 transactions through the legacy MMIS.
- Authorization of services is performed and managed according to program policy.
- There are standardized needs assessment processes for establishing eligibility for CM services.
- Preadmission screening and resident review is performed by the behavioral health managed care contractor.
- MLTC procured a vendor who will perform service authorization processes and will allow providers to submit prior authorization requests via a web portal.

Opportunities for Improvement

- Because of the disparate systems, there are no consolidated authorization/treatment processes, nor a centralized authorization system that has interoperability with claims processing.
- There are no standardized forms and business processes for prior authorization requests.
- There is limited collaboration with other agencies, divisions, and stakeholders for data sharing purposes to support CM activities, including data analytics and performance improvement.
- There are limited methods of communication and document flow between CM staff and other internal units.
- There are limited periodic stakeholder satisfaction reviews for most business processes related to CM.
- Documentation of operating procedures is limited and lacks standardization.

3.3.2.3. Maturity Level Profile

Figure 8 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the business process with the lowest maturity level. As illustrated, the As-Is MITA maturity level for this business area is Level 1, and the six-year To-Be MITA maturity level goal is Level 2.

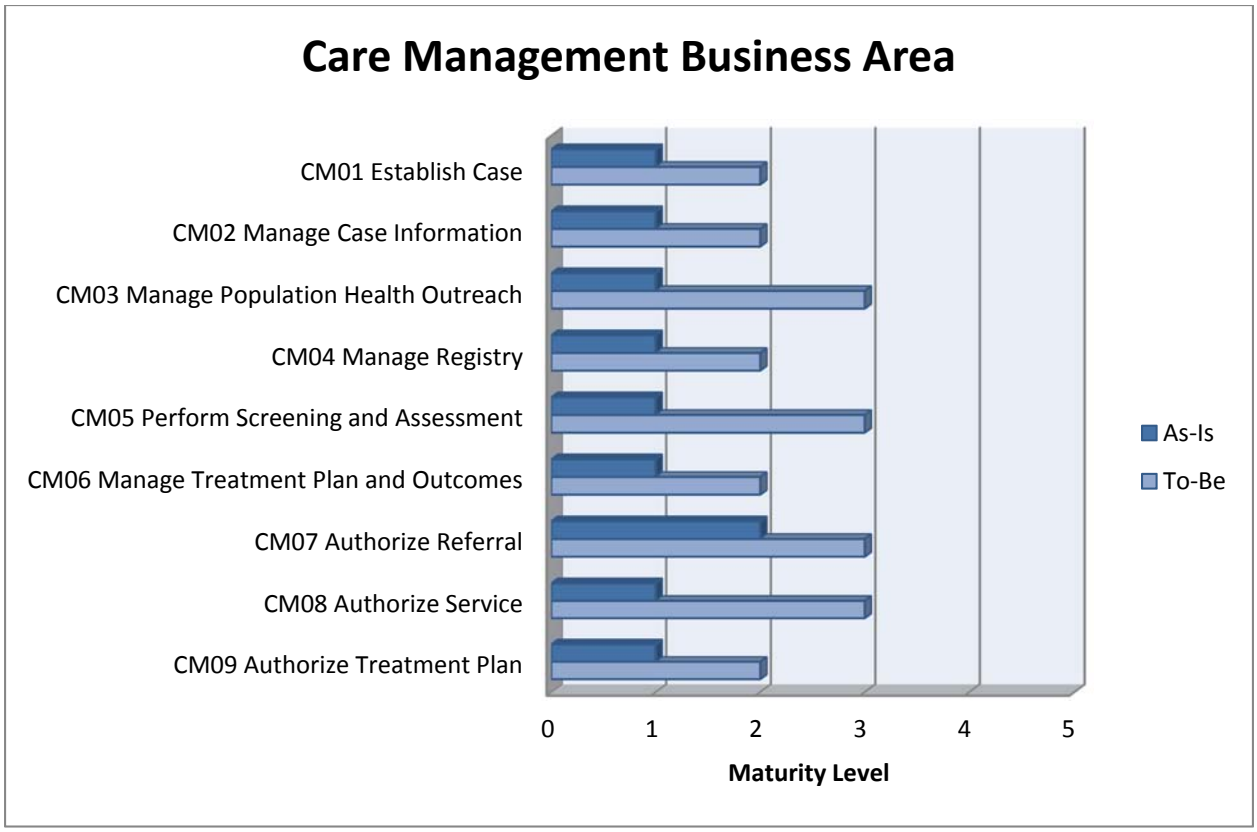


Figure 8 - Care Management Business Area Maturity Levels

3.3.2.4. Care Management – To-Be Summary

The project team facilitated one session with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

Throughout this analysis, the team identified new and/or existing efforts that will enable MLTC to progress to its desired maturity levels. The following projects and initiatives appear on the MITA Roadmap and will contribute to improving the CM maturity level.

High Impact on Business Area Processes and Maturity Levels:

- Enterprise Data Management Strategy (newly identified project)
  - The implementation of a data management governance plan and data management unit will assist MLTC in achieving its maturity goals for the CM business area by allowing the SMA to extract specific data in order to develop new and/or enhanced health care initiatives by reviewing the service needs of its populations.
  - This project also will improve CM processes by increasing the reporting capabilities used to determine a client's treatment plans. This will facilitate the delivery of patient

care in the most cost effective and efficient manner, whether for fee-for-service (FFS) or managed care populations.

- MMIS Replacement (existing project)
  - The MMIS replacement project is expected to enable the consolidation of authorization/treatment processes and provide a centralized authorization system that has interoperability with the claims processing module. This will result in an increase in data and process accuracy, timeliness, standardization, efficiency, and stakeholder satisfaction with the authorization and claims adjudication processes.
- Managed Long-Term Services and Supports (MLTSS) (existing project)
  - MLTC is planning to move the LTSS population into managed care with the hope of improving access to and the quality of the clients' care.
  - This project will allow the Managed Care Unit to develop audit criteria for encounter and clinical data received from the MCOs. This will result in overall improvement of the oversight and management of the MCOs.
- Enterprise Workflow Management Strategy (newly identified project)
  - This project will allow MLTC to advance in maturity levels for the CM business area by automating the distribution of workflow management, alerts, tasks, action status, and reminders between various departments (e.g., Claims, Estate Recovery, Program Management, Program, Program Integrity and Customer Service).
  - The workflow management solution should at minimum have the following functionality:
    - Configurable work queues based on specific business area criteria
    - The ability to send/receive messages to other units and/or departments
    - Configurable alerts, reminders, and action and/or process status
    - Ability to attach and route different documents types among various departments or units
    - Reporting capabilities including configurable ad-hoc reporting
    - Ability to configure different security levels based on management or other staff needs
  - This type of automated functionality will improve business process performance by decreasing the need for manual workflow distributions between departments and units. In addition, it will eliminate existing business process silos within MLTC.
- Transformed Medicaid Statistical Information System (T-MSIS) (existing project)
  - To address the reporting requirements mandated by the ACA, the SMA is working with its sister agencies (e.g., Public Health) to develop the capability to share data between agencies. This indirectly provides an opportunity to enable a "two-way conversation" in which Public Health provides Registry information that assists MLTC ACA reporting; MLTC provides authorized users with claim information to assist Public Health in

improving Registry management. Effective use of existing data can help increase MLTC's MITA maturity level in standardization, accuracy, and cost effectiveness. It will also increase the SSC scores for MITA Condition and Leverage Condition.

- SOPs - Development and Implementation (newly identified project)
  - MLTC is currently developing standardized work processes. This will allow consistency of all CM activities (e.g., establish case, manage case, etc.) regardless of service or program (e.g., personal assistance services (PAS) vs. Developmental Disabilities Waiver services). It will also improve process accuracy, efficiency, cost effectiveness, and stakeholder satisfaction, as well as decrease training time and confusion for new hires.
- Stakeholder Satisfaction Measures - Planning and Implementation (newly identified project)
  - Performing frequent stakeholder (provider and client) satisfaction surveys allows the CM area and its staff to receive feedback from internal and external individuals who are directly affected by the business processes. MLTC will be able to manage and eliminate potential risks in a timely manner. It also will facilitate improvement of patient care and program operations by suggesting best practices and changes to program policies.

Medium Impact on Business Area Processes and Maturity Levels:

- Balancing Incentive Program (BIP) (existing project)
  - While this project will not necessarily increase the maturity level of CM on its own, it does endorse MLTC's commitment to implementing programs and initiatives that will increase the maturity level for cost effectiveness, standardization, and stakeholder satisfaction.

For the detailed gap analysis for this business area, please reference Section 6.3.

3.3.3. Contractor Management

3.3.3.1. Overview

The Contractor Management (CO) business area provides a process framework for SMAs to manage contractors with whom the agency has a contract for services. Examples of the types of contracted entities include:

- MCOs
- Business process management firms
- Recovery audit contractors

- Staff augmentation consulting firms
- Technology services organizations
- Other service vendors

NOTE: Management of agreements between providers and the SMA is addressed in the Provider Management business area.

The CO business area is comprised of the following business processes:

- CO01 – Manage contractor information
- CO02 – Manage contractor communication
- CO03 – Perform contractor outreach
- CO04 – Inquire contractor information
- CO05 – Produce solicitation
- CO06 – Award contract
- CO07 – Manage contract
- CO08 – Close-out contract
- CO09 – Manage contractor grievance and appeal

3.3.3.2. Contractor Management – As-Is Summary

Procurement of contracted services within the Nebraska Medicaid enterprise follows specific and standard guidelines. MLTC administers the procurement for contracts with a value of less than $50,000. The administration of procurement activities for most contracts over $50,000 is managed by DAS. DAS ensures each procurement follows the established procurement process. Administrative contracts are generally executed with either a fixed price or time and materials with a not-to-exceed limit.

Contract financial information is tracked and managed within the Enterprise One system. State contract managers have the ability to generate reports showing contract expiration dates and remaining funds available on the contract. However, no proactive notice/alert capability exists to notify a contract manager of an impending expiration of funds. Contractor payment is managed through a manual purchase order generation process.

There is no standard method for tracking contractor performance and communications. Management of contractor performance is the responsibility of each contract manager within the Division. The contract managers establish their own method for tracking contractor performance and communications.

Strengths

- Updates to contractor information are kept in an automated data store.

- Contract financials are managed in the centralized financial system.
- Procurements follow a well-documented and standardized process.
- MLTC follows the Secretary of State's records management standards.
- MLTC utilizes standard EDI protocols and encourages contractors to do the same.
- MLTC staff have increased their use of SharePoint as a central information repository.
- Contractor information is kept accurate and up-to-date.

Opportunities for Improvement

- There is no standardized process with supporting technology to track contract documents in the contract order of precedence, contract correspondence, and contractor performance.
- MLTC uses a combination of automation and manual submissions for invoicing, through the Enterprise One system. Lack of coordination between the system and manual workflows can result in errors, duplication, and/or rework of invoicing information. Enterprise One is used with many, but not all, types of contracts for accounting and payment purposes; the remainder are handled manually.
- Staff is alerted at the last minute regarding contract or funding expiration thresholds, resulting in errors, duplication, and/or rework of contract review/renewals.
- There is no central DHHS or MLTC reporting system for monitoring contracts across programs, identifying contract issues, monitoring the purchase of similar services, confirming contract results, or monitoring contract expirations.
- While there is anecdotal evidence that stakeholders are satisfied with DHHS management of contracts under $50,000, stakeholder satisfaction is not formally measured.

3.3.3.3. Maturity Level Profile

Figure 9 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the business process with the lowest maturity level. As illustrated, the As-Is MITA maturity level for this business area is Level 1, and the six-year To-Be MITA maturity level goal is Level 2.

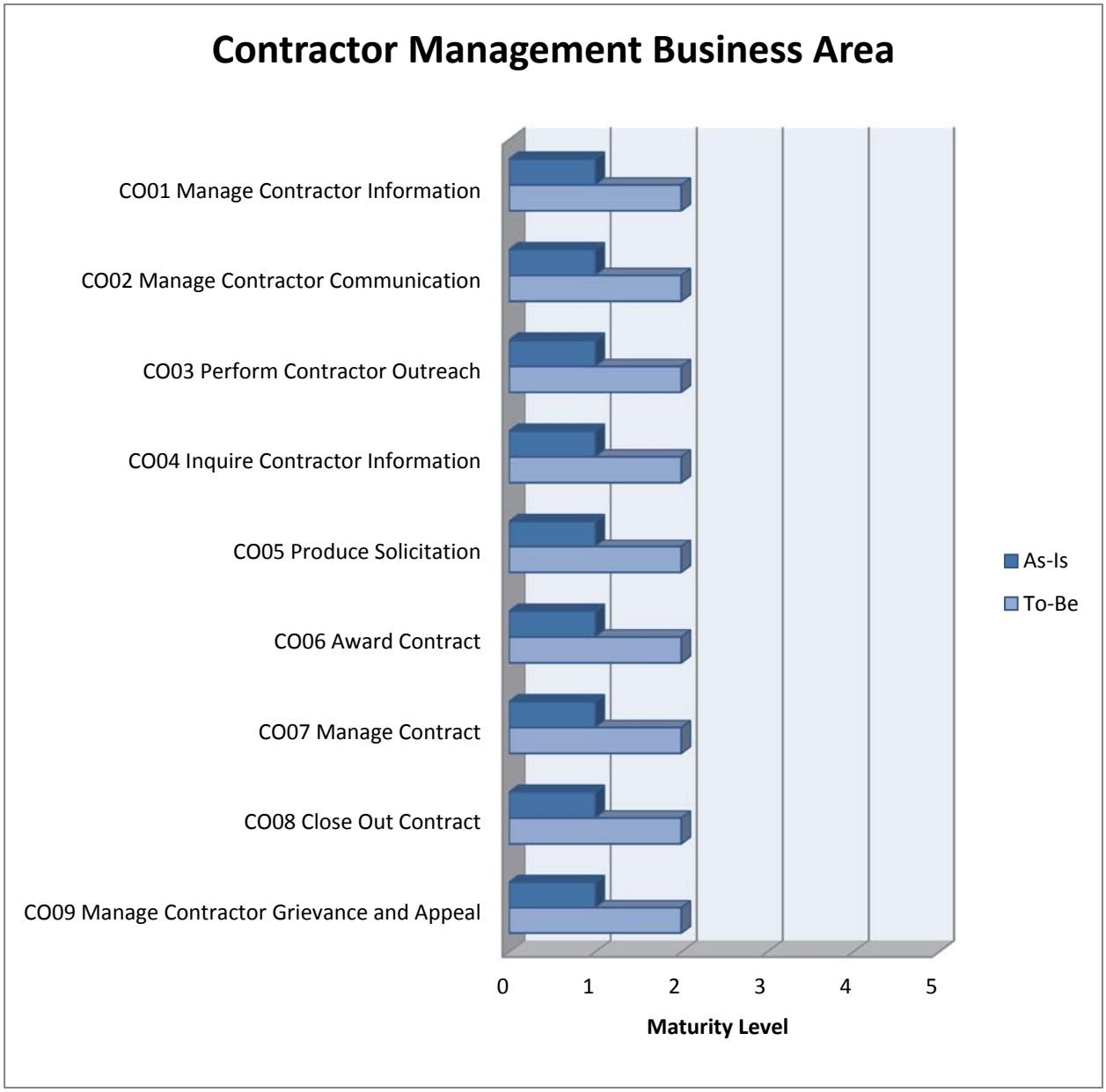


Figure 9 - Contractor Management Maturity Levels

3.3.3.4. Contractor Management – To-Be Summary

The project team facilitated two sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for the CO business area. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

As there is a close relationship between BR and CO (i.e., similar process steps, business rules, same repository of forms, and same State entities involved in the processes), the bulk of recommended projects and initiatives applies to both business areas. The MITA project team

recommends that MLTC considers future steps concurrently in order to achieve process and technology synergies and avoid duplication of effort.

Throughout our analysis, the team identified new and existing efforts that will enable the MLTC to progress to its desired maturity levels. The following projects and initiatives appear on the MITA Roadmap and will improve the CO maturity level.

High Impact on Business Area Processes and Maturity Levels:

- MMIS Replacement (existing project)
  - Replacement of MLTC's MMIS will affect the Division's management of contractor/contract information, communication, and status. MLTC expects that this project will automate and reduce the manual effort between business partners and the Division, thereby improving timeliness, cost effectiveness, and data accuracy. This project will also further the standardization of electronic communications with MLTC's business partners.
  - MMIS functions will facilitate the efficient management of information related to MCOs.
- Enterprise Workflow Management Strategy (newly identified project)
  - MLTC is developing contract workflow management requirements that will meet the automation needs of this business area, and implementing a system to satisfy them. This system will contribute to improved process performance by decreasing the manual coordination between departments and units within the SMA enterprise. Automation of alerts will improve timeliness of contract reviews and renewals. This may include, but is not limited to, work queue management, alerts, tasks, action status, and reminders. There will be configurable reporting capabilities for staff and management.
  - Current notification of contract expiration dates is limited to a monthly report from Enterprise One. A workflow solution that includes timely notification of event dates (e.g. expiration, verification, and renewals of contracts) will reduce errors and increase timeliness and efficiency.
  - MLTC is considering automating the submission of invoices and approvals. This will significantly reduce the cost and effort to process contractor invoices, as there will be an increase in data standardization, data access, and uniform reporting.
  - The automation of these capabilities will promote improvement for all six MITA business qualities, particularly timeliness, cost effectiveness, efficiency, data access, and stakeholder satisfaction.
  - The workflow solution will likely include a web portal to facilitate communication and coordination between MLTC and its business partners.

- These benefits will be achieved in coordination with implementation of a centralized contractor/contract repository (see *MITA Transformation* below).
- The workflow system can be utilized to capture and report performance data for processing each type of contract.
- To achieve Maturity Level 2 for the close out contract business process, increased automation of process steps and information exchange among MLTC unit(s), DHHS Legal Services, DHHS Support Services, DAS, and possibly other entities is recommended. This business process is crucial for program and process integrity, and it should be reviewed to identify opportunities for reduction in cycle time.
- MLTC is considering adding filters to workflow reporting to track contracts by group or area.
- MLTC is reviewing the capabilities of the OnBase document and workflow management application to satisfy some or all of these requirements and reduce the cost of implementing a new system. Increased use of a tool, such as OnBase, for scanning contracts and managing alerts, will increase communication and response time for process completion. Process accuracy and efficiency also will be improved through the automated capture of user comments.
- MLTC is currently determining the additional capabilities of Enterprise One (e.g., including match rates in reports, user security level configuration). This process will examine the extent to which Enterprise One functions and capabilities can be leveraged to further automate contractor/contract management processes. This might include work queue management, alert, tasks, action status, and reminders. There should be extensive configurable reporting capabilities for staff and executive management to utilize, which will improve all six qualities, especially timeliness, cost effectiveness, efficiency, and stakeholder satisfaction.

- MITA Transformation (newly identified project)
  - MLTC plans to develop a central repository of agreements, including MOU, TPAs, SLAs, EDI agreements, business associate agreements, and business and service contracts.
  - This repository will contain all information required to support the BR and CO business areas. It would be capable of providing data filtered or sorted by such criteria as business unit, contract status, contract manager, vendor status, start date, end date, renewal date, type of contract, buyer name, and vendor name.
  - The implementation of this repository would result in increased timeliness, data access, accuracy, cost effectiveness, efficiency, and usefulness to stakeholders.

For the detailed gap analysis for this business area, please reference Section 6.4.

3.3.4. Eligibility and Enrollment Management

3.3.4.1. Overview

The Eligibility and Enrollment Management (EE) business area is a collection of business processes involved in eligibility determination, enrollment, and information management between MLTC and both prospective and enrolled Medicaid clients and providers. This business area also manages the disenrollment processes for both clients and providers. At the time of development of this report, CMS had not finalized the EE processes for clients so the proposed processes were used. Upon finalization of these processes, the SS-A will be updated if necessary. Client EE processes share a common set of client-related data and provider EE processes share a common set of provider-related data. In accordance with the ACA, client EE processes use modified adjusted gross income (MAGI), non-MAGI and combined determination protocols, as well as interfaces with the Federal Hub and the federally-facilitated marketplace (FFM). Inquiries from authorized parties (e.g., providers, MCOs, state agencies, etc.) regarding a client's eligibility status or other information are routed to the appropriate business unit for resolution. The goal for this business area is to improve health care outcomes and raise the level of consumer and provider satisfaction.

The EE business area is comprised of the following business processes:

- EE01 – Determine member eligibility (under CMS development)
- EE02 – Enroll member (under CMS development)
- EE03 – Disenroll member (under CMS development)
- EE04 – Inquire member eligibility (under CMS development)
- EE05 – Determine provider eligibility
- EE06 – Enroll provider
- EE07 – Disenroll provider
- EE08 – Inquire provider information

3.3.4.2. Eligibility and Enrollment Management – As-Is Summary

Member-Related Processes

While MLTC has been successful in implementing the ACA requirements, it still relies on a mix of procedures and systems, some paper-based and some automated, to manage the client relationship lifecycle from application through disenrollment.

In 2013, DHHS completed an organizational restructuring project in which some eligibility tasks were moved from the Children and Family Services Unit to MLTC. As a result, MLTC eligibility

staff can focus on Medicaid-related work. This restructuring resulted in improved eligibility determination times, focused client assistance, and other increased efficiencies.

Provider-Related Processes

Provider screening and enrollment activities rely on paper-based and automated procedures. Recently, provider enrollment and provider support activities have been consolidated into a Provider Relations Unit, enabling closer coordination of the provider relationship lifecycle.

Strengths

Member Eligibility and Enrollment

- MLTC set new standards for developing and maintaining eligibility and change reporting processing guides and other supporting documentation.
- Staff training practices have been enhanced to include process-based as well as policy-based training.

Provider Eligibility and Enrollment

- MLTC has well defined, comprehensive screening and verification procedures.
- Basic performance measures have been established.
- MLTC monitors provider process efficiency.

Opportunities for Improvement

Member Eligibility and Enrollment

- When standard interfaces (Federal Hub, employment/wage verifications, other data matches) do not provide sufficient data, the process for manual verification of income and other data is cumbersome, reduces timeliness, and impedes stakeholder satisfaction.
- There is no standardized measure of performance (e.g. timeliness, efficiency, stakeholder satisfaction) aside from the ACCESSNebraska 195 report to CMS.

Provider Eligibility and Enrollment

- This increase in standardized automation solutions will support the desired reductions in process turnaround time. Provider eligibility and enrollment processes are still primarily paper-based; this results in inefficiencies when determining eligibility and coordinating with related business areas (Provider Management, Financial Management, etc.).
- Providers must submit paper/fax applications to be a Medicaid provider. This process is prone to error, duplication, rework, and inaccuracies.
- Provider re-certification and re-credentialing are manual processes, prone to error and inefficiency.
- There is no standardized measure for stakeholder satisfaction.

3.3.4.3. Maturity Level Profile

Figure 10 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the business process with the lowest maturity level. As illustrated, the As-Is MITA maturity level for this business area is Level 1, and the six-year To-Be MITA maturity level goal is Level 2.

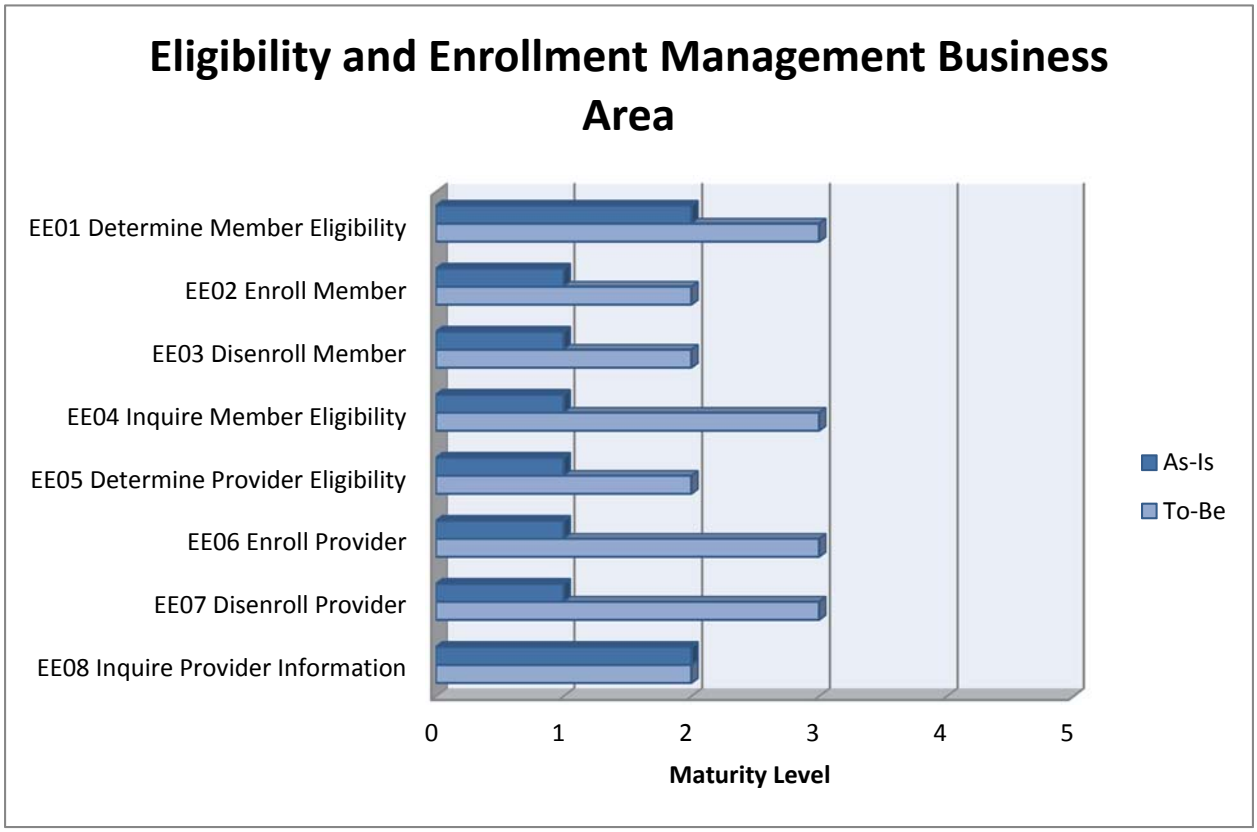


Figure 10 - Eligibility and Enrollment Management Maturity Levels

3.3.4.4. Eligibility and Enrollment Management – To-Be Summary

Given the differences between member and provider processes within this business area, this section is divided into member and provider processes to provide a more detailed To-Be analysis.

Member Processes (EE01, EE02, EE03, EE04)

The project team facilitated one session with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. MLTC expects the maturity level of this business area to progress in the next six years to a maturity level of 2.

Throughout this analysis, the team identified new and/or existing efforts that will enable MLTC to progress to its desired maturity levels. The following projects and initiatives appear on the MITA Roadmap and will contribute to improving the EE maturity level.

High Impact on Business Area Member Processes and Maturity Levels:

- EES (existing project)
  - The new EES will replace EE functionality of the current Medicaid EE system. It will automate numerous eligibility determination functions from application receipt through application routing, applicant verifications, and eligibility determinations, as well as transfer information between MLTC and the FFM.
  - The new EES will enable administrative changes to business rules without requiring program changes, thereby improving cost effectiveness and efficiency. The ability to perform business rule reconfiguration functions will enable MLTC to respond more effectively to changes in policy or regulations as well as other operational/process requirements.
  - The new EES will demonstrate measurable alignment with the MITA framework and the SSCs, particularly with respect to Modularity, MITA, Interoperability, Industry Standards, Business Results, and Reporting Conditions.
  - It will provide increased automation of the MAGI eligibility determination process, thereby improving timeliness, cost effectiveness, and accuracy.
- MMIS Replacement (existing project)
  - Replacement of Nebraska's current MMIS will vastly improve MLTC's data management exchange and reporting capabilities. New opportunities will be available for integration of client-related, provider-related, and claims-related information. MLTC expects that the new system will reduce manual activities between itself and other entities (e.g., DHHS Legal Services, Support Services, and Financial Services, and external trading partners) as well as standardizing electronic communication, and improving timeliness, cost effectiveness, and data accuracy.
  - MMIS functions will contribute to more efficient management of information related to client and provider eligibility, enrollment and outreach, and managed care interactions.

Medium Impact on Business Area Member Processes and Maturity Levels:

- Performance Measures - Planning and Implementation (newly identified project)
  - MLTC is developing a standard set of methods, practices, and technologies to measure and report on the Division's progress in aligning with the MITA framework and the SSCs.

- MLTC plans to measure, report, and assess the degree of MITA alignment demonstrated by implementation of the new EES, as well as a process for continuous, measurable improvement in MITA alignment.

Provider Processes (EE05, EE06, EE07, EE08)

The project team facilitated two sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. MLTC expects the maturity level of this business area to progress in the next six years to a maturity level of 2.

Throughout the analysis, the team identified new or existing efforts that will enable MLTC to progress to its identified maturity levels. The following projects and initiatives appear on the MITA Roadmap and will contribute to improving the EE maturity level.

High Impact on Business Area Provider Processes and Maturity Levels:

- PS&E (existing project)
  - The new PS&E will provide an automated, unified, and standardized set of capabilities for performing database checks (active, new, returning, and revalidating providers), conducting site visits, collecting and managing application fees, and enforcing temporary moratoria. It will also enable providers to submit applications electronically and enable tracking of each step in the enrollment process. This will improve timeliness, efficiency, accuracy, cost effectiveness, and stakeholder satisfaction.
  - The PS&E will be integrated into the new MMIS, thus improving efficiency, cost effectiveness, timeliness, data access, and accuracy.
  - This initiative will provide electronic provider application and tracking capability through a web portal. It will increase timeliness, data access and accuracy, efficiency, cost effectiveness, and stakeholder satisfaction.
  - The new PS&E will support initiation and management of provider outreach in coordination with provider associations. This will also improve efficiency, cost effectiveness, and stakeholder satisfaction.
- MMIS Replacement (existing project)
  - Replacement of Nebraska's current MMIS will vastly improve MLTC's data management exchange and reporting capabilities. New opportunities will be available for integration of client-related, provider-related, and claims-related information. MLTC expects that the new system will reduce manual activities between itself and other entities (e.g., DHHS Legal Services, Support Services, and Financial Services, and external trading partners) as well as standardizing electronic communication, and improving timeliness, cost effectiveness, and data accuracy.

  - MMIS functions will contribute to more efficient management of information related to client and provider eligibility, enrollment and outreach, and managed care interactions.
- Electronic Health Record (EHR) Incentive Payment Program (existing project)
  - Automation of the Medicaid Incentive Program (MIP) standards and practices continues. This will permit the capturing and reporting of meaningful use (MU) measures, business rules for achieving levels of MU use, compliance with CMS reporting requirements, and support of data analysis requirements.
  - Improvements in the ability to receive enrollments, MU measures, and other documentation from providers and the ability to deploy interfaces for file transfers with CMS and provide accurate reporting to CMS will result in improved timeliness, efficiency, cost effectiveness, data access and accuracy, and stakeholder satisfaction.

Medium Impact on Business Area Provider Processes and Maturity Levels:

- HIE (existing project)
  - Nebraska Health Information Initiative (NeHII) is the lead HIE in Nebraska. Implementation of this initiative will enable NeHII to assist Medicaid providers in achieving MU of their EHR technology, which is one of the qualifications for the EHR Incentive Payment Program.
  - MLTC's capability to exchange key data with the HIE and with its business partners will be enhanced, resulting in improved processing, standardized data exchange, and increased stakeholder satisfaction (providers will be supported in reaching their MU goals).
- Performance Measures - Planning and Implementation (newly created project)
  - MLTC plans to develop standard methods, practices, and technologies to measure and report on its progress in aligning with MITA framework and the SSCs.
  - MLTC will establish a method for measuring, reporting, and assessing the degree of MITA alignment demonstrated by implementation of the new PS&E, as well as a process for continuous, measurable improvement in MITA alignment.

For the detailed gap analysis for this business area, please reference Section 6.5.

3.3.5. Financial Management

3.3.5.1. Overview

The Financial Management (FM) business area is the largest of the MITA 3.0 business areas. MITA defines the FM business area as a collection of business processes to support the payment of:

- Providers

- MCOs
- Insurers
- Medicare premiums
- Other agencies
- Contractors

FM also supports the receipt of payments from other insurers (third-party liability [TPL]), providers, client premiums and/or share of cost, estate recovery, and prescription drug rebates. These processes share a common set of payment and receivable-related data.

The FM business area is comprised of the following business processes:

- 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 funds
- FM08 – Prepare member premium invoice
- FM09 – Manage contractor payment
- FM10 – Manage member financial participation
- FM11 – Manage capitation payment
- FM12 – Manage incentive payment
- FM13 – Manage accounts payable information
- FM14 – Manage accounts payable disbursement
- FM15 – Manage 1099
- FM16 – Formulate budget
- FM17 – Manage budget information
- FM18 – Manage fund
- FM19 – Generate financial report

3.3.5.2. Financial Management – As-Is Summary

While disparate systems and processes initiate financial receivable and payable transactions within the Nebraska Medicaid enterprise, the core functionality and processes of making a payment and receiving payments within Financial Services is handled by the Enterprise One system. The individual business processes that trigger these financial activities are mostly manual accompanied by some automation. A significant opportunity exists for efficiency within these triggering processes through process standardization and automation.

Fiscal management, including the activities to formulate, manage, and report on budget information, is also mostly manual and labor intensive. MLTC is currently using a commercial off-the-shelf budget management software application that does not include predictive modeling, forecasting, or other robust reporting features.

Data for reporting are maintained in disparate systems and require substantial manual effort to assemble meaningful program reports. The financial system can identify actual expenses within each fund, but the ability of program managers and executives to manage the use of those funds is limited; this is due primarily to erroneous reporting caused by missing or incorrect data manually entered into disparate systems. Financial reporting to CMS is also negatively affected by these factors.

Strengths

- The tracking of program receipts and expenditures is standardized and consolidated into a central financial system.
- All capitation payment generation is automated within the MMIS.
- A significant number of payments are made through EFT instead of a paper check.
- FM processes have enabled the Nebraska Medicaid enterprise to continue to meet the needs of its external stakeholders.

Opportunities for Improvement

- Providers do not have the capability to respond and track recoupments on-line or associate recoupments to claims.
- The TPL recovery process is mostly manual and very time consuming. Process accuracy is inconsistent due to a lack of client information.
- The processes for identifying health insurance premium payment (HIPP) clients and their associated TPL are not automated. The manual processes require excessive time to complete.
- There is a limited standardized process to handle the receipt of all refund checks regardless of department and/or the reason the request was triggered.
- Double data entry of HIPP information is required due to disparate systems (data entry is required in both N-FOCUS and MMIS).
- MMIS does not have the capability to reconcile and adjust capitation payments. This process is performed manually and is extremely time consuming and error prone.
- There is limited meaningful data across MLTC used for analytics by program and finance staff and the executive team to support decision-making.
- There is no automation of predictive modeling and expenditure forecasting processes to assist in the development of the bi-annual budget.
- There is limited periodic stakeholder satisfaction reviews for most business processes.

- Documentation of procedures is limited and lacks standardization.

3.3.5.3. Maturity Level Profile

Figure 11 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the business process with the lowest maturity level. As illustrated, the As-Is MITA maturity level for this business area is Level 1, and the six-year To-Be MITA maturity level goal is Level 2.

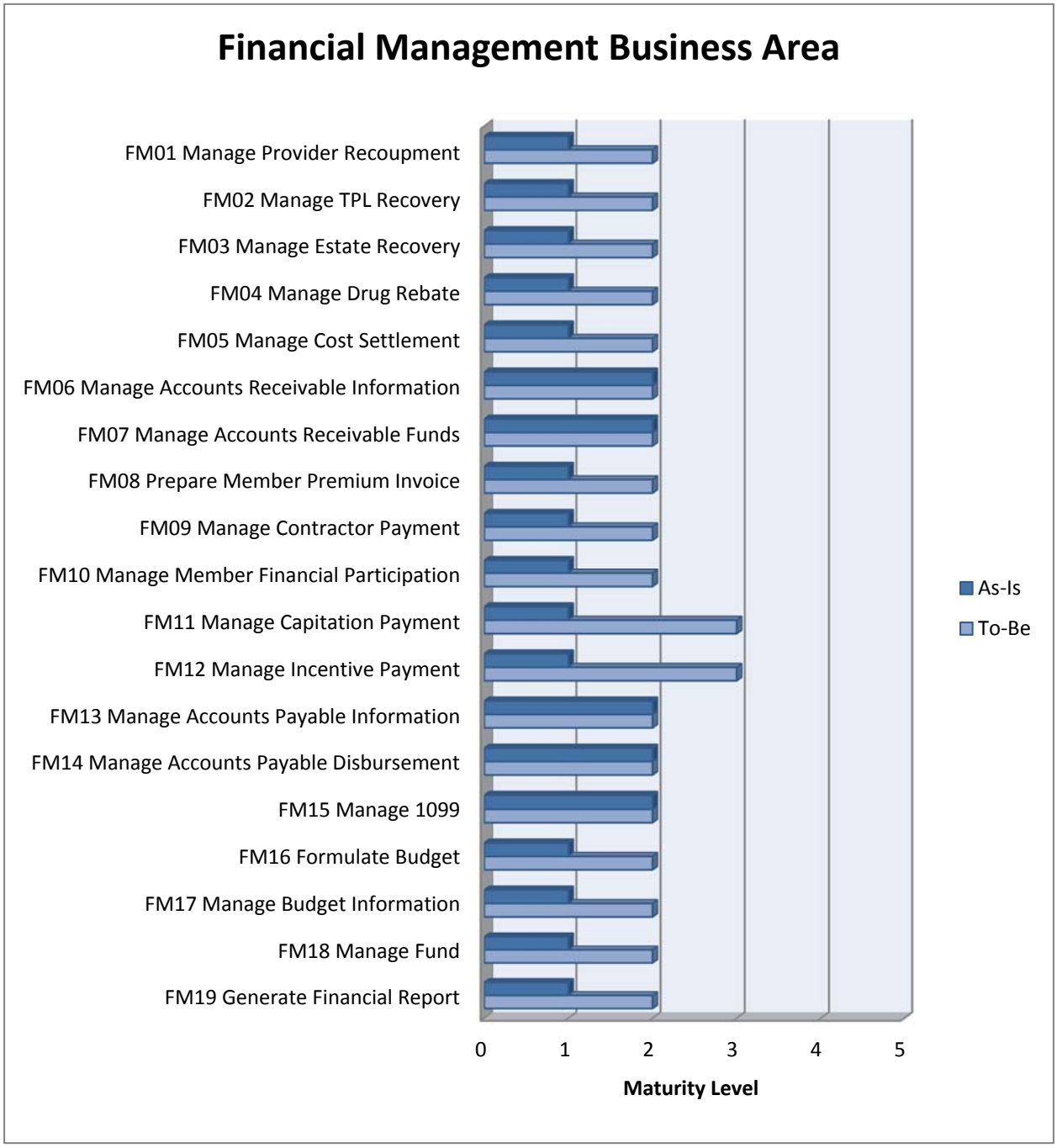


Figure 11 - Financial Management Maturity Levels

3.3.5.4. Financial Management – To-Be Summary

The following FM business processes within the MITA framework are currently not within the scope of the Nebraska SMA enterprise and the SMA has no authority over decision-making for these processes:

- FM06 – Manage accounts receivable information
- FM07 – Manage accounts receivable funds
- FM13 – Manage accounts payable information
- FM14 – Manage accounts payable disbursement
- FM15 – Manage 1099

However, since these processes are considered essential in supporting all other business processes within the Medicaid enterprise, they were reviewed for maturity levels and recommendation were made, but only when both the MLTC and Financial Services SMEs were involved and agreed with the recommendation(s).

The project team facilitated five sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

Throughout the analysis, the team identified new and/or existing efforts that will enable the SMA to progress to its identified maturity levels. The following projects and initiatives appear on the MITA Roadmap and will improve the FM maturity level.

High Impact on Business Area Processes and Maturity Levels:

- Enterprise Data Management Strategy (newly identified project)
  - The implementation of a data management governance plan and data management unit will assist MLTC in achieving its maturity goals by facilitating the development of a logical data structure for the disparate systems. This will permit the FM area to create consistent, easily accessible and meaningful data extracts that can be used in day-to-day tasks, budget analytics, and reporting. This will increase the maturity levels of data access and accuracy, efficiency, standardization, cost effectiveness, and stakeholder satisfaction.
- MMIS Replacement (existing project)
  - The MMIS replacement project will indirectly impact all FM areas because all Medicaid service payments funnel directly to the financial area.
  - With the modernization of the MMIS, the following financial processes will be significantly influenced:
    - Capitation payment and adjustments
    - Estate recovery
    - TPL recovery
    - Provider recoupment
    - Drug rebate
    - Cost settlement

The project team embraced a conservative scoring approach on all FM business processes listed above except for capitation payments. This conservative approach was used because of several unknowns related to the MMIS replacement project and the impact it will have on these business areas. As for capitation payments, almost any MMIS currently on the market will supply the capability for auto-adjusting capitation payments and utilization of the standard EDI 835 transaction for refunds. These capabilities are required for this process to move up to level 3 maturity.

It is expected that the processes listed will all advance to level 2 maturity at a minimum (capitation payments will advance to level 3), by increasing the automation of these processes and expanding the interfacing and interoperability capabilities of the MMIS with other systems (e.g., Enterprise One, EES and PS&E).

- EHR Incentive Payment (existing project)
  - It is expected that with the implementation of this project, the manage incentive payments process will advance to a level 3 maturity by increasing automation and standardization of processes, and improving MITA qualities for efficiency, timeliness, accuracy, and stakeholder satisfaction. In addition, the MIP will begin data sharing with other entities such as the National Level Repository.
- CMS Quarterly Reports (existing project)
  - This project will have a significant impact on advancing the maturity level for the financial reporting processes. The process for generating financial reports (CMS-64, CMS-37, CMS-21B) will improve dramatically by increasing the collaboration/communication between MLTC and the Department's Financial & Program Analysis Unit. This will result in more accurate collection of data from the disparate systems (e.g., MMIS, N-FOCUS) and documentation of work procedures, which will improve process accuracy, efficiency, and stakeholder satisfaction.
- SOPs - Development and Implementation (newly identified project)
  - MLTC is currently developing standardized work processes. Use of SOPs will ensure that program policies and State regulations are applied in a consistent and efficient manner by the various financial departments. It will improve the MITA qualities of accuracy of process and cost effectiveness by decreasing adjustments caused by erroneous claims processing. In addition, it will increase overall stakeholder satisfaction. Documented SOPs will also assist in the reduction of new hire training time and reduce confusion for both new hires and existing staff.
- Stakeholder Satisfaction Measures - Planning and Implementation (newly identified project)
  - Developing and performing stakeholder satisfaction surveys for all FM areas will help to break down any silos that exist between MLTC, Financial Services, and other

stakeholders. This will result in increased coordination and cooperation between the two areas.

- Enterprise Workflow Management Strategy (newly identified project)
  - This project will allow MLTC to advance in maturity levels for the FM business area. It will automate the distribution of workflow management, alerts, tasks, action status, and reminders between various departments (e.g., Claims, Estate Recovery, Program Management, Program, Program Integrity, and Customer Service).
  - The workflow management solution should at minimum have the following functionality:
    - Configurable work queues based on specific business area criteria
    - The ability to send/receive messages to other units and/or departments
    - Configurable alerts, reminders, and action and/or process status
    - Ability to attach and route different documents types among various departments or units
    - Reporting capabilities including configurable ad-hoc reporting
    - Ability to configure different security levels base on management or other staff needs
  - This type of automated functionality will improve the business process performance by decreasing the need for manual workflow distributions among departments and units. In addition, it will eliminate existing business process silos within MLTC.
- T-MSIS (existing project)
  - MLTC is currently addressing the new reporting requirements mandated by the ACA. Because of this initiative, the SMA is now developing improved reporting capabilities by reaching out to sister agencies (e.g., Public Health) to develop the capability to share data between agencies. This will increase MLTC's MITA maturity levels in standardization, accuracy, and cost effectiveness. This will also increase the SSCs for MITA Condition and Leverage.

For the detailed gap analysis for this business area, please reference Section 6.6.

3.3.6. Member Management

3.3.6.1. Overview

The Member Management (ME) business area addresses interactions between MLTC and Medicaid applicants or clients. At the time of development of this report, CMS had not finalized the ME processes so the proposed processes were utilized. Upon finalization, the SS-A will be updated if necessary.

The ME business area is comprised of the following business processes:

- ME01 – Manage member information (under development)
- ME02 – Manage applicant and member communication
- ME03 – Perform population and member outreach
- ME08 – Manage member grievance and appeal

3.3.6.2. Member Management – As-Is Summary

Management of client communications and information is a mix of manual and automated procedures. The N-FOCUS system supports all aspects of client data store management, providing interfaces with MMIS and other internal systems as well as standardized interfaces with federal data stores. Day-to-day management of communication with applicants and clients is primarily automated. With the implementation of ACA business rules and standards, a robust set of consistent and coherent desktop processes for coordination with applicants and clients, including clear call routing and application routing procedures, was developed. Coordination with other business areas is primarily manual, with some support from the N-FOCUS system.

The enrollment broker, Medicaid Enrollment Center Inc, performs outreach to clients enrolled in managed care. This outreach consists of a notice of enrollment and information about enrolling in managed care and the managed care benefits package.

Contact with MLTC may be made via telephone, web portal, email, mail, fax, or in person. Various communications with clients are accomplished through the N-FOCUS system; these communications include letters of notification, verification requests, and other types of correspondence. Outreach activities include notifying existing or prospective clients about new benefits or health care initiatives, or processes MLTC might use to identify underserved populations.

Strengths

- As with the EE business area, MLTC (during the ACA compliance project) developed SOPs, useful not only for improving service to clients, but also for use in staff training. With the change in staff responsibilities to Medicaid exclusively, this business area was able to focus specifically on Medicaid client assistance.
- N-FOCUS was enhanced to enable automated alerts between Medicaid and the Division of Children & Family Services when clients' enrollment status spanned programs.
- MLTC is using the CMS Monthly Performance Indicator as a model in its expansion of performance measurement standards and practices.

Opportunities for Improvement

- While the processes for eligibility, enrollment, and change management have been improved in the context of ACA implementation, most activities not directly related to real-time updates of the client data store are manual and prone to error.
- Processes for obtaining requested verification or validation information, such as reporting unearned income, is cumbersome and time-consuming when standard process automation/interfaces do not provide sufficient data (e.g. timely/accurate information not found on Federal Hub or other interfaces such as SEW and TALX).
- The grievance and appeals process is managed primarily through Excel spreadsheets, PDF documents, and Outlook mailboxes, impeding improvements in timeliness, data access, and stakeholder satisfaction.
- There are no standard performance measures to track effectiveness, timeliness, and cost factors in ME processes.
- There is no standardized set of measures or a process for assessing stakeholder satisfaction within this business area. There is little coordination of effort with other business areas (e.g. Eligibility and Enrollment Management, Provider Management, Contractor Management, and Financial Management) to expand standardized data management systems and practices across the Nebraska Medicaid enterprise.

3.3.6.3. Maturity Level Profile

CMS has not published assessment criteria for MITA 3.0 for this business area. Therefore, maturity cannot be fully and accurately assessed.

3.3.6.4. Member Management – To-Be Summary

The project team facilitated two sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

Throughout this analysis, the team identified new or existing efforts that will enable the SMA to progress to its identified maturity levels. The following projects and initiatives appear on the MITA Roadmap and will improve the ME maturity level.

High Impact on Business Area Processes and Maturity Levels:

- EES (existing project)
  - The new EES will replace EE functionality of the current Medicaid EE system. It will enable administrative changes to business rules without requiring program changes, thereby improving cost effectiveness and efficiency.

  - The new EES will demonstrate measurable alignment with MITA framework and the SSCs, particularly with respect to Modularity, MITA, Interoperability, Industry Standards, Business Results, and Reporting Conditions.
  - The new system will increase MLTC's ability to capture and save client data, thereby improving data access and accuracy. It will also facilitate the managing of client information, communication, and outreach.
  - The new EES will increase capability to coordinate data management and exchange with the MCOs, resulting in increased data access and accuracy and process efficiency.
  - Through the new system, MLTC will automate enrollment of eligible clients into managed care, thereby improving data access, accuracy, efficiency, cost effectiveness, and stakeholder satisfaction.
- Enterprise Workflow Management Strategy (newly identified project)
  - Grievances and appeals are processed through several intrastate entities using Excel spreadsheets, PDF documents, and Outlook mailboxes. As there is a variety of types of grievances and appeals, it is recommended that MLTC lead a review of this business process with the objective of identifying opportunities for automation of process workflows using standardized formats, tracking and reporting statuses, and setting of alerts for follow-up. This will positively impact the measurements of timeliness, data accuracy and access, efficiency, cost effectiveness, and stakeholder satisfaction.
- MMIS Replacement (existing project)
  - Replacement of Nebraska's current MMIS will vastly improve MLTC's data management exchange and reporting capabilities. New opportunities will be available for integration of client-related, provider-related, and claims-related information. MLTC expects that the new system will reduce manual activities between itself and other entities (e.g., DHHS Legal Services, Support Services, and Financial Services, and external trading partners) as well as standardizing electronic communication, and improving timeliness, cost effectiveness, and data accuracy.
  - MMIS functions will contribute to more efficient management of information related to client and provider eligibility, enrollment and outreach, and managed care interactions.

For the detailed gap analysis for this business area, please reference Section 6.7.

3.3.7. Operations Management

3.3.7.1. Overview

The Operations Management (OM) business area is a collection of nine business processes that manage claims and prepare premium payments. This business area uses a specific set of claims-related data and includes processing (i.e., editing, auditing, and pricing); a variety of claim forms

including professional, dental, institutional, pharmacy, and encounters; and sends payment information, remittance advice, and/or claim status to the provider.

The OM business area is comprised of the following business processes:

- OM04 – Submit electronic attachment
- OM05 – Apply mass adjustment
- OM07 – Process claims
- OM14 – Generate remittance advice
- OM18 – Inquire payment status
- OM20 – Calculate Spend-Down Amount
- OM27 – Prepare provider payment
- OM28 – Manage data
- OM29 – Process encounters

3.3.7.2. Operations Management – As-Is Summary

OM activities within the Nebraska Medicaid enterprise are not all performed through standardized processes and/or systems. While the majority of FFS claims are submitted to MMIS by the provider and follow a standard process, there are claims that are processed through exception processing such as:

- Claims submitted to a Service Coordinator prior to submission to MMIS
- Claims submitted to N-FOCUS for adjudication
- Claims submitted to CONNECT for adjudication
- Claims that are data entered prior to scanning and claims that are scanned and then data entered
- Claims that are submitted to Enterprise One for payment for home or technology modification services

Providers can submit claims electronically through EDI 837 transactions, or via fax or mail. Claims' attachments are submitted via fax or mail. The handling of paper claims and attachments, whether faxed or mailed, is manually intensive and involves significant internal routing of paper.

Remittance advices are generated and mailed through a standard process and system regardless of the submission method. Remittance advices can be received through an 835 EDI transaction. No method currently exists for providers to view or print a remittance advice through web access. Providers are able to inquire on claim payment status electronically for claims processed within MMIS. For those claims not processed within MMIS, providers are referred to the appropriate program area for claim status inquiry.

Share of cost calculation and tracking is a manual process that requires extensive exception processing within MLTC and by external stakeholders.

Strengths

- The Nebraska Medicaid enterprise is HIPAA 5010 compliant for 837 and 835 EDI transactions.
- For the majority of claims, providers are able to inquire about their status through MLTC's website, 276 / 277 EDI transactions, or via telephone.
- Claims are processed for payment according to state policies and regulations.
- Remittance advice processing is standardized regardless of submission method or system.

Opportunities for Improvement

- There are disparate claim processing, adjudication, and inquiry systems for FFS claims, resulting in complexity and sub-optimal operational efficiency.
- The current MMIS is a legacy system and inflexible. The cost to change program policy and services within the current MMIS is expensive and time consuming, resulting in limitations on the design of programs and program policies.
- There is limited web-based capability. Providers can only view paid or denied claims and do not have the option to submit claims or electronic attachments through the web portal. The online portal also does not allow providers to view and print a remittance advice.
- The imaging system is not integrated or interoperable with MMIS. Staff can only view images and have no capability to make notations to an image.
- The MMIS currently does not have the capability to automatically calculate and track clients' share of cost. All calculation tracking is done manually, which is error prone.
- Documentation of procedures is outdated for some processes and lacks standardization.

3.3.7.3. Maturity Level Profile

Figure 12 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the business process with the lowest maturity level. As illustrated, the As-Is MITA maturity level for this business area is Level 1, and the six-year To-Be MITA maturity level goal is Level 2.

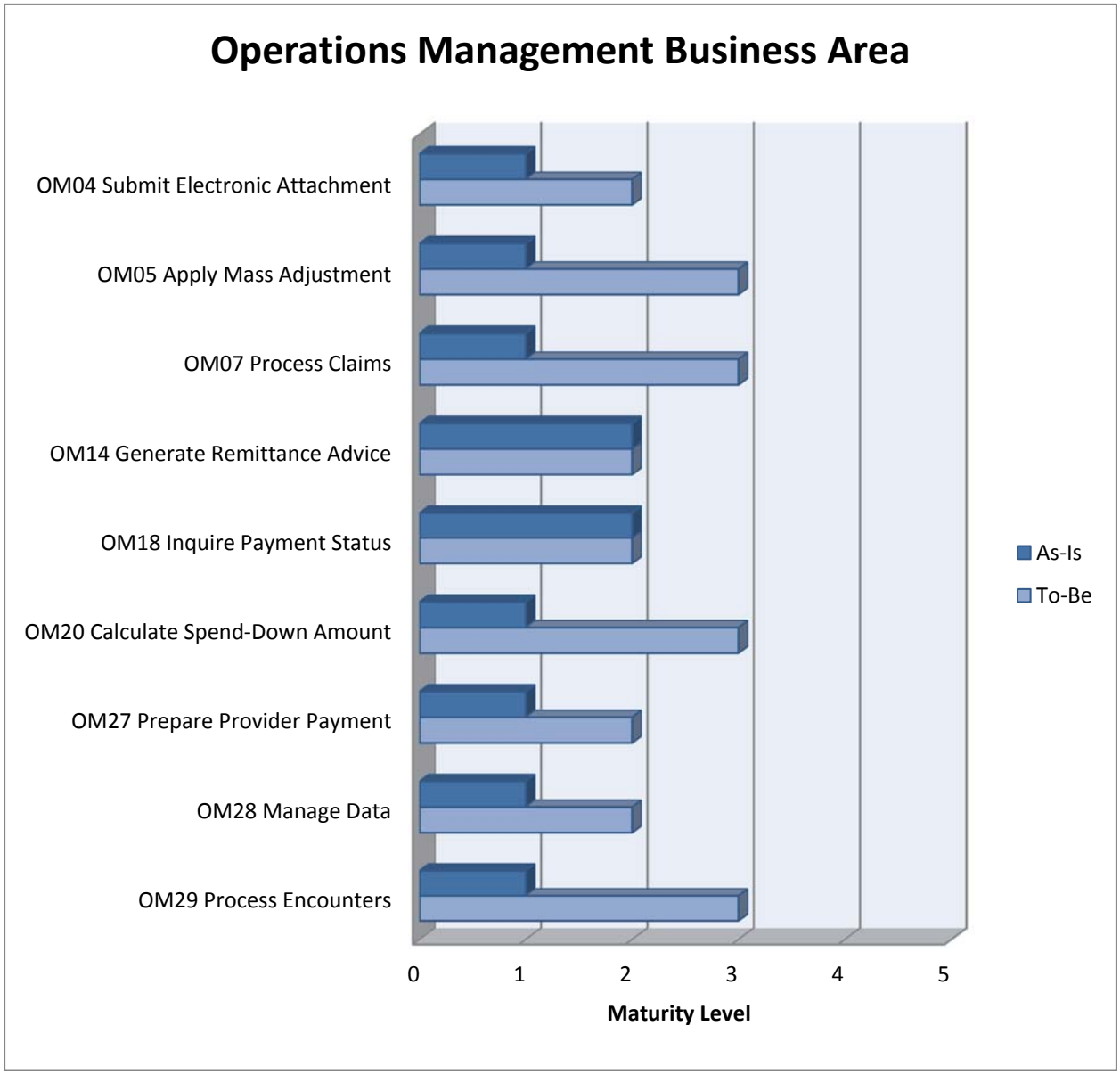


Figure 12 - Operations Management Maturity Levels

3.3.7.4. Operations Management – To-Be Summary

The project team facilitated four sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. The project team embraced a conservative approach when scoring the OM, because of uncertainties with the MMIS modernization project. Some assumptions were made about basic functionalities that the new MMIS will possess. These assumptions were based on MITA team members experience with other MMIS implementations and knowledge that a new MMIS with basic functionality would

advance some processes exponentially while improving other processes to a lesser degree. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

Throughout the analysis, the team identified new or existing efforts that will enable MLTC to progress to its desired maturity levels. The following projects and initiatives appear on the MITA Roadmap and will contribute to improving the OM maturity level.

High Impact on Business Area Processes and Maturity Levels:

- MMIS Replacement (existing project)
  - Replacement of Nebraska's current MMIS will have the most influence on advancing every business process within the OM area. It is expected that this initiative will increase system flexibility, automation, integration, and interoperability with other systems (e.g., Enterprise One, EES) and standardization of processes. This will increase the maturity levels for accuracy of process and data, timeliness, efficiency, standardization, and stakeholder satisfaction, resulting in a more cost-effective program.
- Enterprise Data Management Strategy (newly identified project)
  - MLTC plans to develop and implement a data management governance plan and data management unit prior to the MMIS procurement. This will ease the transition to the new MMIS and assist with a logical data structure for the current disparate systems. The result will be consistent, easily accessible, and meaningful data extracts across the OM area. This will increase the maturity of access, efficiency, standardization, data accuracy, cost effectiveness and stakeholder satisfaction.
- SOPs - Development and Implementation (newly identified project)
  - The development or updating of existing SOPs for all processes will ensure that program policies and State regulations are applied in a consistent and efficient manner. It will also improve process accuracy and cost effectiveness due to a decrease in adjustments and increase stakeholder satisfaction. Documented processes will also facilitate requirements gathering for the new MMIS. In addition, SOPs will reduce new hire training time and alleviate confusion for both new and existing staff.
- MITA Transformation Project (newly identified project)
  - This project is a conglomeration of recommended projects the MITA team considers necessary for MLTC to reach the MITA maturity goals for the different business process areas within the MITA framework. For the OM area, the focus is on automating client share of cost, increasing the accuracy of fee schedule publications on the Web, and giving providers enhanced web portal capabilities for claims inquiry. Implementation of these three projects prior to the MMIS procurement will

immediately improve the automation of these processes, and increase MITA maturity levels for accuracy of process and data, efficiency, and stakeholder satisfaction.
  - MLTC is considering convening a workgroup to review these projects and determine the cost effectiveness of enhancing the current MMIS and provider portal, or waiting for the MMIS procurement.
- Stakeholder Satisfaction Measures - Planning and Implementation (newly identified project)
  - Developing and performing stakeholder satisfaction surveys for all OM areas will help to break down any silos that exist between MLTC and other stakeholders. This will result in increased coordination and cooperation between MLTC and its stakeholders.
- Performance Measures - Planning and Implementation (newly identified project)
  - MLTC is establishing defined and quantifiable performance measures for those business processes that lack useful measures. By having targeted measurements, the SMA can identify core reasons for possible bottlenecks (and errors that impact a specific process), resolve them, and track current progress and improvements. These enhancements will increase timeliness, efficiency, process accuracy, stakeholder satisfaction, and cost effectiveness.
- T-MSIS (existing project)
  - MLTC is currently addressing the new reporting requirements mandated by the ACA. Because of this initiative, the SMA is developing improved reporting capabilities by reaching out to sister agencies (e.g., Public Health) to develop the capability to share data between agencies. This will increase MLTC's MITA maturity level in standardization, accuracy, and cost effectiveness. It will also increase the SSC for MITA and Leverage conditions.
- Enterprise Workflow Management Strategy (newly identified project)
  - This project will allow MLTC to advance in maturity levels for the OM business area by automating the distribution of workflow management, alerts, tasks, action status, and reminders between various departments (e.g., Claims, Estate Recovery, Program Management, Program, Program Integrity, and Customer Service).
  - The workflow management solution should at minimum have the following functionality:
    - Configurable work queues based on specific business area criteria
    - The ability to send/receive messages to other units and/or departments
    - Configurable alerts, reminders, and action and/or process status
    - Ability to attach and route different documents types among various departments or units
    - Reporting capabilities including configurable ad-hoc reporting

- Ability to configure different security levels base on management or other staff needs

This type of automated functionality will improve business process performance by decreasing the need for manual workflow distributions between departments and units. In addition, it will eliminate existing business process silos within MLTC.

For the detailed gap analysis for this business area, please reference Section 6.8.

3.3.8. Performance Management

3.3.8.1. Overview

The Performance Management (PE) business area is a collection of business processes used to assess program compliance (e.g., auditing and tracking of 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 client (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 utilization and performance functions.

The PE business area is comprised of the following business processes:

- PE01 – Identify utilization anomalies
- PE02 – Establish compliance incident
- PE03 – Manage compliance incident information
- PE04 – Determine adverse action incident
- PE05 – Prepare REOMB (Recipient Explanation of Medical Benefits)

3.3.8.2. Performance Management – As-Is Summary

PE processes throughout the Nebraska Medicaid enterprise are performed through significant manual effort and paper workflow, and are tracked within Microsoft Access databases. There are few standardized processes and procedures documented to enable consistent implementation of performance measures by MLTC staff.

While the Surveillance and Utilization Review Subsystem (SURS) is CMS-certified, all utilization review is retrospective and involves traditional SURS measurements. Escalation of fraud cases to the Medicaid Fraud Control Unit (MFCU) are performed manually with paper case files being provided to MFCU.

Each month, MLTC randomly samples and sends out 200 REOMB letters to clients for their review. In addition, each Nebraska-contracted MCO is required to send out 200 randomly selected REOMB statements each month.

Managed care utilization is performed and managed within the individual MCOs and reported to MLTC. MCO encounter data is generally not reviewed or leveraged for utilization management purposes.

Strengths

- Retrospective reviews are performed to identify potential utilization and compliance issues.
- There is a clear policy for escalation of potential fraud cases to MFCU.
- The SMA will be issuing an RFP this year to solicit bids for a quality improvement organization to manage statewide quality and utilization control program for Medicaid clients.
- MLTC procured an external quality review organization in 2014 to perform quality review of MCOs and prepaid inpatient health plans.
- MLTC is developing more robust and standardized quality measures and processes for MCO oversight.

Opportunities for Improvement

- There is limited automation of processes to identify utilization and compliance concerns prior to claims payment.
- There is limited utilization review follow-up or corrective action planning for targeted groups. MLTC currently has performance measures for utilization review for:
  - Drug utilization
  - Quality review, including the Healthcare Effectiveness Data and Information Set and the Consumer Assessment of Healthcare Providers and Systems
  - MCOs (limited)
  - Erroneous payment (retroactive only)
  - Internal audit (performed by audit team)
  - Review of key performance indicators (generally limited to claims)
  - Investigation of potential fraud or abuse
  - Provider utilization review
  - Provider compliance review
- Tasks for managing performance measures are mostly manual, causing staff to focus more on administrative work (e.g., developing and updating spreadsheets and templates, etc.), instead of establishing and enforcing utilization criteria for targeted groups (e.g., providers, contractors, etc.).

- Encounter data received from MCOs is not used to evaluate the accuracy of MCO utilization reports.
- There are limited stakeholder satisfaction reviews for most business processes.
- The existence and use of SOPs are limited. Those that exist lack standardization.
- No online portal capabilities exist for clients to view their claims history and REOMBs.

3.3.8.3. Maturity Level Profile

Figure 13 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the business process with the lowest maturity level. As illustrated, the As-Is MITA maturity level for this business area is Level 1, and the six-year To-Be MITA maturity level goal is Level 2.

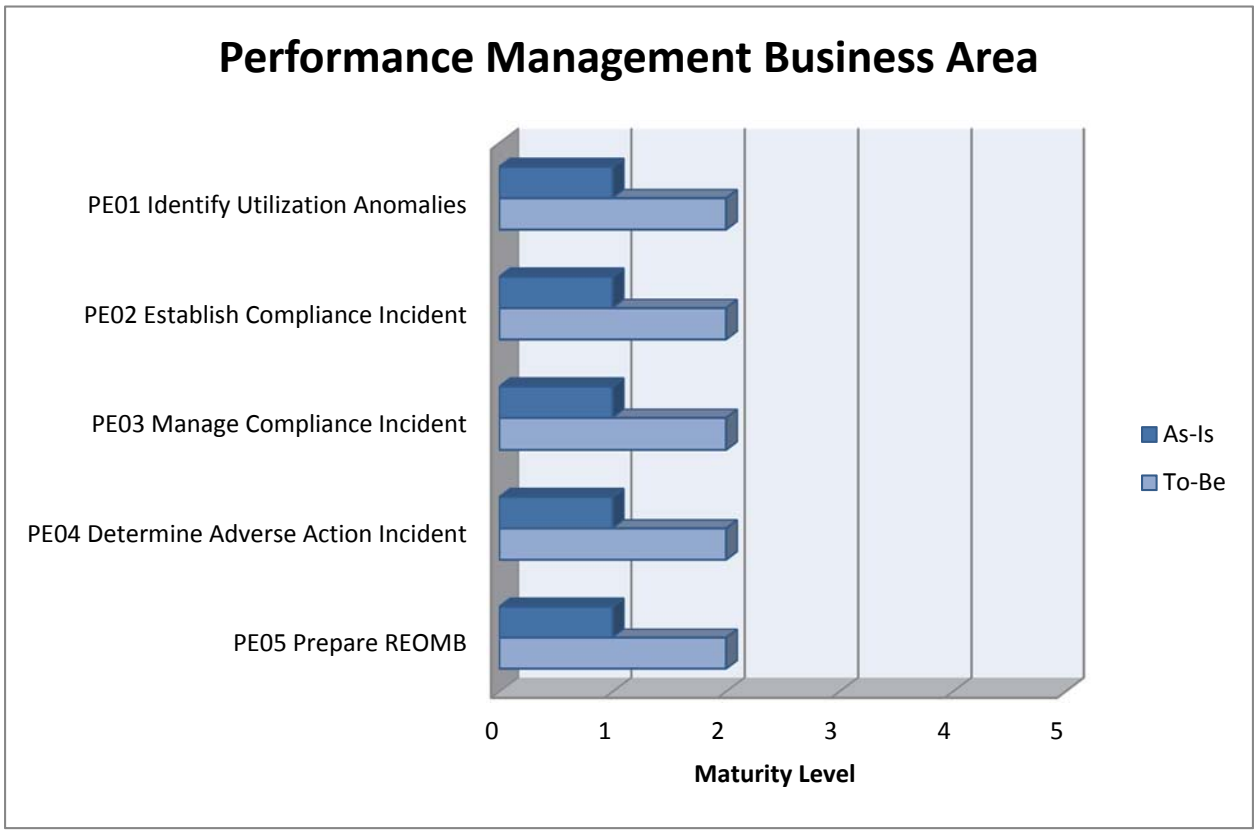


Figure 13 - Performance Management Maturity Levels

3.3.8.4. Performance Management – To-Be Summary

The project team facilitated two sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

Throughout the analysis, the team identified new or existing efforts that will enable MLTC to progress to its desired maturity levels. The following projects and initiatives appear on the MITA Roadmap and will contribute to improving the PE maturity level.

High Impact on Business Area Processes and Maturity Levels:

- Performance Measures - Planning and Implementation (newly identified project)
  - MLTC is establishing defined and quantifiable performance measures for those business processes in the Program Integrity (PI) Unit that lack useful measurements. By having targeted measures, the Division can identify core reasons for possible bottlenecks (and errors that impact a specific process), resolve them, and track current progress and improvements. These enhancements will increase timeliness, efficiency, process accuracy, stakeholder satisfaction, and cost effectiveness.
  - In addition to defining the PI Unit's performance measurements, it will also expand the criteria and rules to identify additional targeted groups (e.g., contractors, trading partners) and establish patterns or parameters of acceptable and unacceptable behavior for these groups. By doing this, MLTC will be able to create a baseline to identify outliers that demonstrate suspicious utilization of program benefits. This will increase the MITA maturity levels for accuracy and cost effectiveness.
- Enterprise Data Management Strategy (newly identified project)
  - The implementation of a data management governance plan and data management unit will assist MLTC in achieving its maturity goals by facilitating the development of a logical data structure for the disparate systems. This will permit the PE area to create consistent, easily accessible and meaningful data extracts that can be used in day-to-day tasks. This will increase the maturity levels of data access and accuracy, efficiency, standardization, cost effectiveness, and stakeholder satisfaction.
- MMIS Replacement (existing project)
  - MMIS modernization will likely increase system flexibility, automation and standardization of processes, and facilitate the development of useful performance measures for MCO encounter data oversight.
  - MLTC anticipates that the new MMIS will have online portal capabilities so clients can review claims payment history and REOMB. This will increase maturity levels for accuracy of process and data, timeliness, efficiency, standardization, cost effectiveness, and stakeholder satisfaction.
- SOPs - Development and Implementation (newly identified project)
  - The development or updating of existing SOPs for all processes will ensure that program policies and State regulations are applied in a consistent and efficient manner. This will reduce new hire training time and effort and alleviate confusion for

both new and existing staff. Improvements will result in accuracy of process, cost effectiveness, and stakeholder satisfaction.

- Stakeholder Satisfaction Measures - Planning and Implementation (newly identified project)
  - Developing and performing stakeholder satisfaction surveys for all PE areas will help to break down any silos that exist between MLTC and other stakeholders. This will result in increased coordination and cooperation.
- T-MSIS (existing project)
  - MLTC is currently addressing the new reporting requirements mandated by the ACA. Because of this initiative, the SMA is developing improved reporting capabilities by reaching out to sister agencies (e.g., Public Health) to develop the capability to share data between agencies. This will increase MLTC's MITA maturity level in standardization, accuracy, and cost effectiveness. It will also increase the SSC for MITA and Leverage conditions.
- MITA Transformation Project (newly identified project)
  - This project is a conglomeration of recommended projects the MITA team considers necessary for MLTC to reach the MITA maturity goals for the different business process areas within the MITA framework. For the PE area, the focus is on acquiring an automated case tracking solution for PI that will increase process automation, and improve efficiency, standardization, accuracy of process, and stakeholder satisfaction.
- Enterprise Workflow Management Strategy (newly identified project)
  - This project will allow MLTC to advance in maturity levels for the PE business area by automating the distribution of workflow management, alerts, tasks, action status, and reminders between various departments (e.g., Claims, Estate Recovery, Program Management, Program, Program Integrity, and Customer Service).
  - The workflow management solution should at minimum have the following functionality:
    - Configurable work queues based on specific business area criteria
    - The ability to send/receive messages to other units and/or departments
    - Configurable alerts, reminders, and action and/or process status
    - Ability to attach and route different documents types among various departments or units
    - Reporting capabilities including configurable ad-hoc reporting
    - Ability to configure different security levels based on management or other staff needs

This type of automated functionality will improve business process performance by decreasing the need for manual workflow distributions between departments and units. In addition, it will eliminate existing business process silos within MLTC.

For the detailed gap analysis for this Business Area, please reference Section 6.9.

3.3.9. Plan Management

3.3.9.1. Overview

The Plan Management (PL) business area includes eight business processes that support strategic planning, policymaking, monitoring, and oversight of contractors, such as MCOs. These activities require access to timely and accurate data and the use of analytical tools. The goal of this business area is for the SMA to move away from the focus of daily operations (e.g., number of claims paid) and strategically focus on how to meet the needs of their clients within a prescribed budget.

The PL business area is comprised of the following business processes:

- PL01 – Develop agency goals and objectives
- PL02 – Maintain program policy
- PL03 – Maintain State Plan
- PL04 – Manage health plan information
- PL05 – Manage performance measures
- PL06 – Manage health benefit information
- PL07 – Manage reference information
- PL08 – Manage rate setting

3.3.9.2. Plan Management – As-Is Summary

MLTC currently has an operations-focused business process structure that uses key indicators to measure claims volume, claims paid per period, claims processing time, providers enrolled, and clients enrolled. In order for the PL processes to be effective, MLTC must have accurate and complete data that can be properly analyzed. This data should be used to determine program change cost-effectiveness, identify and implement industry best practices, and improve process results while supporting MLTC's goals and objectives.

Performance results are produced by manually combining multiple reports. This practice is necessitated because of disparate information systems, databases, and spreadsheets across departments and processes. MMIS, CONNECT, and N-FOCUS cannot always accept data from other entities. This results in data not being available for the data warehouse, which limits program analytics and correct reporting.

The process to manage rate changes varies with the type of rate (e.g., behavioral health rates are handled differently from Healthcare Common Procedure Code System [HCPS] pricing). Rates are updated manually. Policy and program reviews are performed but only when:

- An ad hoc request is received.
- A contract expires and a new contract needs to be procured.
- There is a federal or State regulation change.
- There is a legislative or judicial mandate.
- There are external quality review findings.

MLTC does not use a benefit package structure for determining and implementing benefits. When benefit changes are made to a program, it is time-consuming to make the changes in MMIS, CONNECT, and N-FOCUS. These systems are hardcoded and have to be re-coded each time there is a change.

Strengths

- When triggered, program and policy reviews are performed.
- Business process representatives collaborate with senior management and other internal stakeholders when developing agency goals and objectives.
- Key operational indicators are regularly monitored for claims payment, and provider and client enrollment.
- MCOs provide quarterly performance measures reports.

Opportunities for Improvement

- There is limited meaningful data across the Medicaid enterprise to allow for analysis to support decision making.
- Development of agency goals and objectives is not formally documented or maintained in one central location to be viewable by internal and external stakeholders.
- There are limited SOPs for managing and loading rates into MMIS, and those that exist are not standardized.
- There is limited documentation for reviewing, developing and updating program policies.
- The current MMIS is a legacy system and inflexible. MMIS does not use configurable benefit package structures, which results in sub-optimal administration of program services.
- There are few stakeholder satisfaction surveys for most business processes.

3.3.9.3. Maturity Level Profile

Figure 14 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the

business process with the lowest maturity level. As illustrated, the As-Is MITA maturity level for this business area is Level 1, and the six-year To-Be MITA maturity level goal is Level 2.

Figure 14 - Plan Management Maturity Levels

3.3.9.4. Plan Management – To-Be Summary

The project team facilitated three sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

Throughout the analysis, the team identified new or existing efforts that will allow MLTC to progress to its identified maturity levels. The following projects and initiatives appear on the MITA Roadmap and will contribute to improving the PL maturity level.

High Impact on Business Area Processes and Maturity Levels:

- MMIS Replacement (existing project)
  - It is expected that the new MMIS will include a configurable benefit package structure. This will give MLTC more system flexibility and allow staff to more easily adjust benefit packages across programs.
  - The new MMIS will support MLTC in its review and auditing of MCO encounter data, and managing rate changes and reference data. This will increase MITA maturity levels for the PL business area for accuracy of process and data, timeliness, efficiency, standardization, cost effectiveness, and stakeholder satisfaction.
- Enterprise Data Management Strategy (newly identified project)
  - The implementation of a data management governance plan and data management unit will assist MLTC in achieving its maturity goals by facilitating the development of a logical data structure for the disparate systems. This will allow for consistent, easily accessible and meaningful data extracts that can be used throughout the PL area, to develop agency goals and objectives and for other program improvement purposes. This will increase the maturity levels of data access and accuracy, efficiency, standardization, cost effectiveness, and stakeholder satisfaction.
- MITA Transformation Project (newly identified project)
  - This project is a conglomeration of recommended projects the MITA team considers necessary for MLTC to reach the MITA maturity goals for the different business process areas within the MITA framework. For the PL area, the focus is implementing quarterly or yearly processes to review, develop, and update program policies to ensure that MLTC's goals and objectives are met. In addition to creating a comprehensive index for the State Plan, staff could easily search and update a specific area of the State Plan and all changes would be maintained for historical purposes. Also, there should be a standard process for developing, publishing, and communicating the Division's goals and objectives. The combination of these recommended projects will improve efficiency, standardization, accuracy of process, and stakeholder satisfaction.
- Enterprise Workflow Management Strategy (newly identified project)
  - This project will allow MLTC to advance in maturity levels for the PE business area by automating the distribution of workflow management, alerts, tasks, action status, and reminders between various departments (e.g., Claims, Estate Recovery, Program Management, Program, Program Integrity, and Customer Service).

  - The workflow management solution should at minimum have the following functionality:
    - Configurable work queues based on specific business area criteria
    - The ability to send/receive messages to other units and/or departments
    - Configurable alerts, reminders, and action and/or process status
    - Ability to attach and route different documents types among various departments or units
    - Reporting capabilities including configurable ad-hoc reporting
    - Ability to configure different security levels base on management or other staff needs
  - This type of automated functionality will improve business process performance by decreasing the need for manual workflow distributions between departments and units. In addition, it will eliminate existing business process silos within MLTC.
- SOPs - Development and Implementation (newly identified project)
  - The development or updating of existing SOPs for all processes will ensure that program policies and State regulations are applied in a consistent and efficient manner. It will also assist in the reduction of new hire training time and effort and alleviate confusion for both new and existing staff, which will improve accuracy of process, cost effectiveness, and stakeholder satisfaction.
- Stakeholder Satisfaction Measures - Planning and Implementation (newly identified project)
  - Developing and performing stakeholder satisfaction surveys for all PL areas will help to break down any silos that exist between MLTC and other stakeholders. This will result in increased coordination and cooperation.
- T-MSIS (existing project)
  - MLTC is currently addressing the new reporting requirements mandated by the ACA. Because of this initiative, the SMA is developing improved reporting capabilities by reaching out to sister agencies (e.g., Public Health) to develop the capability to share data between agencies. This will increase MLTC's MITA maturity level in standardization, accuracy, and cost effectiveness. It will also increase the SSC for MITA and Leverage conditions.

For the detailed gap analysis for this business area, please reference Section 6.10.

3.3.10. Provider Management

3.3.10.1. Overview

The Provider Management (PM) business process manages the SMA's repository of data associated with provider processes for outreach, communication, information updates,

termination, and grievances and appeals. The repository is used to support payment processing for FFS claims.

PM provides standard processes for how the SMA receives and responds to inquiries from providers regarding provider enrollment status, payment rules, billing guidelines, etc. It includes communication from the agency to targeted, or all, providers on topics including, but not limited to, policies, new programs, and public health alerts.

The PM business area is comprised of the following business processes:

- PM01 – Manage provider information
- PM02 – Manage provider communication
- PM03 – Perform provider outreach
- PM07 – Manage provider grievance and appeal
- PM08 – Terminate provider

3.3.10.2. Provider Management – As-Is Summary

Once a provider is enrolled, this business area handles all coordination activities. If the provider is part of a MCO network, then coordination regarding the provider-client relationship and claims payment occurs between the provider and the MCO.

Correspondence from providers is handled by MLTC's Customer Service unit. The correspondence may include inquiries, complaints, requests, or claims adjustments. These inquiries can be in the form of telephone calls, letters, faxes, or email. MLTC employs the HIPAA Eligibility Transaction System 270/271 to respond to eligibility inquiries and complies with mandated operating rules.

MLTC is a participant in the MIP and interfaces with the National Level Repository. Currently, management of MIP-related data is manual, but MLTC is investigating acquisition of an automated solution.

Any changes in a provider's data are recorded in the MMIS provider database. A manual process is used between MLTC and the Nebraska Secretary of State's Office (SOS) to update the SOS provider data store.

MLTC has a web portal for providers to inquire about his or her eligibility status or the status of a claim. Limited access to MMIS screens is also provided to enrolled providers for purposes of verifying a client's eligibility status.

Provider outreach is supported by DHHS Communications and Legislative Services, primarily through:

- Website postings
- Provider bulletins
- Email list-serve distribution
- Mass mailings
- Remittance advice messages

Provider bulletins are posted on the Provider Information page of the DHHS website.

Strengths

- Improvements to support PM processes were made recently by creation of a Provider Relations unit.
- MLTC has clearly defined provider communications protocols and procedures for handling provider grievances and appeals.
- MLTC had implemented well-defined protocols for processing Medicaid PI-related appeals that comply with the Nebraska Administrative Code. Reports to CMS are submitted using standard HITECH interfaces.

Opportunities for Improvement

- Most of the interactions between MLTC and its providers are handled manually. For example, provider documents cannot be electronically submitted. This impedes improvements in timeliness, efficiency, accuracy, and stakeholder satisfaction.
- Currently, web portal functions are very basic and offer limited access.
- There is no standardized process for measuring stakeholder satisfaction.
- There is no formalized agreement with NeHII, which limits enhanced coordination and standardization opportunities for Medicaid providers' MU initiatives.

3.3.10.3. Maturity Level Profile

Figure 15 illustrates the current As-Is and preliminary six-year To-Be maturity levels for each business process within this business area. The maturity level of the business area is equal to the business process with the lowest maturity level. As illustrated, the maturity level for this business area is 1.

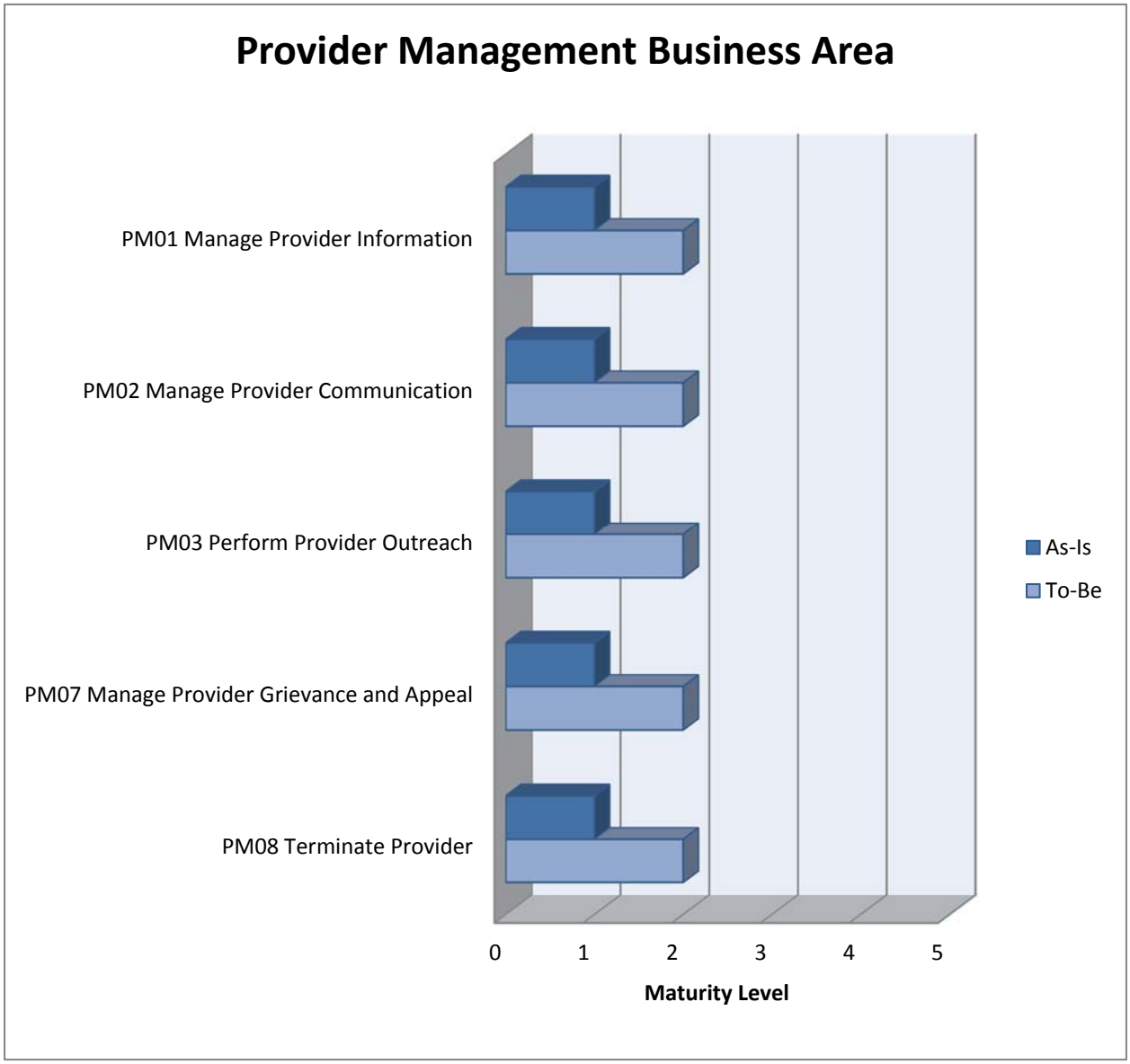


Figure 15 - Provider Management Maturity Levels

3.3.10.4. Provider Management – To-Be Summary

The project team facilitated three sessions with business area stakeholders to collaboratively analyze and determine the To-Be maturity level for this business area. Over the next six years, MLTC expects this business area to progress to a maturity level of 2.

Throughout the analysis, the team identified new or existing efforts that will allow MLTC to progress to its identified maturity levels. The following projects and initiatives appear on the MITA Roadmap and will contribute to improving the PM maturity level.

High impact on Business Area Processes and Maturity Levels:

- PS&E (existing project)
  - The new PS&E will provide an automated, unified, and standardized set of capabilities for performing database checks (active, new, returning, and revalidating providers), conducting site visits, collecting and managing application fees, and enforcing temporary moratoria. It will also provide electronic provider application and tracking capability through a web portal. These capabilities will improve timeliness, efficiency, accuracy, cost effectiveness, and stakeholder satisfaction.
  - The new PS&E will comply with HIPAA privacy and security rules and HITECH business associate and TPAs. This will also improve timeliness, efficiency, cost effectiveness, and stakeholder satisfaction.
  - This solution will be leveraged to support automated updates to provider data that were previously handled manually, as well as updates to MIP-related data. Additionally, increased automation may include logging and tracking of provider communications, such as general inquiries and correspondence, EDI adjustments, complaints, requests, claims adjustments, EDI enrollment forms, share of cost forms, and electronic attachments. The new PS&E will be required to align with the MITA framework and the SSCs for enhanced funding.
  - The new PS&E will be integrated into the new MMIS, thus improving efficiency, cost effectiveness, timeliness, data access, and accuracy.
  - The new PS&E will support initiation and management of provider outreach in coordination with provider associations. This will also improve efficiency, cost effectiveness, and stakeholder satisfaction.
- MMIS Replacement (existing project)
  - Replacement of Nebraska's current MMIS will vastly improve MLTC's data management exchange and reporting capabilities. New opportunities will be available for integration of client-related, provider-related, and claims-related information. MLTC expects that the new system will reduce manual activities between itself and other entities (e.g., DHHS Legal Services, Support Services, and Financial Services, and external trading partners), as well as standardizing electronic communication, and improving timeliness, cost effectiveness, and data accuracy.
  - MMIS functions will contribute to more efficient management of information related to client and provider eligibility, enrollment and outreach, and managed care interactions.

Medium Impact on Business Area Processes and Maturity Levels:

- EHR Incentive Payment Program (existing project)
  - Automation of the MIP standards and practices continues. This will permit the capturing and reporting of MU measures, business rules for achieving levels of MU,

compliance with CMS reporting requirements, and support of data analysis requirements.
    - Improvements in the ability to receive enrollments, MU measures, and other documentation from providers; and the ability to deploy interfaces for file transfers with CMS and provide accurate reporting to CMS will result in improved timeliness, efficiency, cost effectiveness, data access and accuracy, and stakeholder satisfaction.
- AS-EFT/ERA (existing project)
    - This initiative will improve the standardization of electronic communication between MLTC and its trading partners. However, it will not increase maturity level as it only represents the 835 EDI transactions.
- AS-ECS (existing project)
    - This initiative will also improve the standardization of electronic communication between MLTC and its trading partners. However, it will not increase maturity level as it only represents the 270/271 EDI transactions. It will contribute to process timeliness.
- HIE (existing project)
    - As the lead HIE in Nebraska, implementation of this initiative will enable NeHII to assist Medicaid providers in achieving MU of their EHR technology, which is one of the qualifications for the EHR Incentive Program.
    - MLTC's capability to exchange key data with the HIE and with its business partners will be enhanced, resulting in improved processing, standardized data exchange, and increased stakeholder satisfaction (providers will be supported in reaching their MU goals).
- Enterprise Workflow Management Strategy (newly identified project)
    - Grievances and appeals are processed through several intrastate entities using Excel spreadsheets, PDF documents, and Outlook mailboxes. As there is a variety of types of grievances and appeals, it is recommended that MLTC lead a review of this business process with the objective of identifying opportunities for automation of process workflows using standardized formats, tracking and reporting statuses, and setting of alerts for follow-up. This will positively impact the measurements of timeliness, data accuracy and access, efficiency, cost effectiveness, and stakeholder satisfaction.
    - A separate plan may be required for updates of appeal information to the HITECH Resources & Solutions User Interface for MIP eligibility and enrollment appeals.

For the detailed gap analysis for this Business Area, please reference Section 6.11.

4. MITA SS-A Technical and Information Assessment Results

This section presents the results of the MITA SS-A Information and Technical Architecture As-Is assessments. The first section, Current Systems, describes the primary systems that support the Medicaid program, and identifies which of these systems were included in the scope of the IA and TA assessments. The remaining sections, As-Is Technical Architecture and As-Is Information Architecture, provide a look at the assessment results, which include the overall maturity level by architecture capability, the breakdown of the overall maturity level by system, and a summary of the notable findings from the assessments.

4.1. Current Systems

The Nebraska Medicaid Agency utilizes a wide array of systems in the delivery of its business services. These systems and technical services, illustrated in Figure 16, run the gamut of application architectures, systems technologies, operations models, and hosting scenarios. Some of the systems, such as the MMIS, are owned, operated, maintained, and hosted by DHHS and the Office of the Chief Information Officer (OCIO). Others, such as the Verisk NCCI, are delivered as services that are owned, operated, maintained, and hosted by an external third party entity.

IS&T MITA 3.0 IA & TA Scope

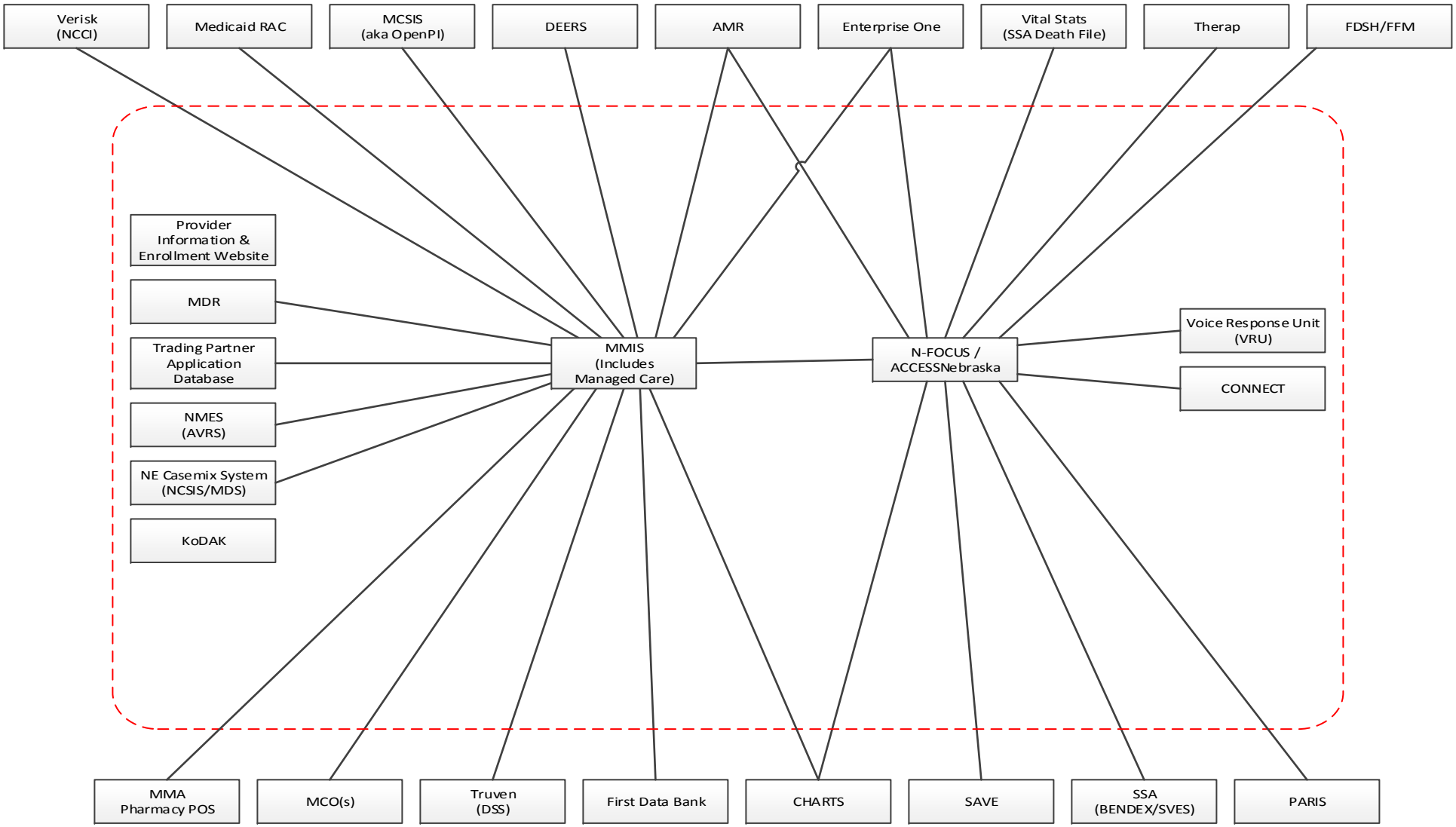


Figure 16 - MITA 3.0 IA & TA Scope

In order to manage the scope of the IA and TA assessments, the team focused on systems and technical services that are under the control of MLTC, DHHS IS&T, and the OCIO. Therefore, for this technical assessment, the scope of systems included in the analysis included the ten primary systems listed in Table 7.

• Medicaid Management Information System (MMIS) including Managed Care • Nebraska Family Online Client User System (N-FOCUS)/ACCESSNebraska • Coordinating Options in Nebraska Network Through Effective Communication and Technology (CONNECT) • Medicaid Drug Rebate (MDR) • KoDak/Prior Authorization	• Casemix • Trading Partner Application Database • Provider Information and Enrollment website • Nebraska Medicaid Eligibility System (NMES) • N-FOCUS Voice Response Unit (VRU)

Table 7 - Primary Medicaid Systems Included in Technical Assessment

Due to the inherent complexity of the systems in this assessment, the involvement of systems SMEs was crucial. Therefore, As-Is assessment meetings were held with the SMEs as part of the information collection/verification process. For each of the ten systems in scope, the team prepared a straw man scorecard that included an initial set of maturity levels for each IA technical area and TA functional assessment area.

During the assessment process, the team held follow-on meetings with the SMEs to discuss and revise the initial maturity levels using the CMS MITA 3.0 IA and TA capability matrices as reference points for scoring program support, architecture, software, data types, and interfaces. In addition, the project team gathered specific information related to the systems for supporting evidence references. After conducting these meetings, the team members documented their findings in the IA technical area and TA maturity level templates that formed the basis of the IA technical area and TA scorecards and profiles.

The final IA technical area and TA findings, scorecards, and profiles were then loaded into ReadyCert. This is the tool that the SMA is using to capture and maintain the SS-A maturity level scoring and supporting documentation.

Based on the results of the IA and TA As-Is assessments, the following observations were made:

- **System and Data Ownership:** Each of the Divisions has primary management and ownership of the systems that fall into their functional domains, therefore system management varies across the systems assessed. Data is managed at a system level with ownership and stewardship of the data residing with the manager of that system. Data governance varies in both approach and execution among the existing systems.

- **Data Modeling:** There is a noticeable absence of conceptual and logical modeling within the environment. While physical models exist for many of the systems, some are outdated and others are an output of the development tool used as opposed to data modeling discipline. The variability in modeling standards and adoption of modeling techniques has resulted in systems with data models that are difficult to rationalize.

- **Reporting and Analytics:** Business area management within MLTC does not have access to the data and analytics that are needed to support the business. In many cases, the data exists, but there is no clear path to obtain the data or understanding where the data exists within one of the systems. In many cases where reporting or analytics are available, they are not trusted as different answers are received from different systems. Further, the context of how the data is pulled is not clearly explained with the analysis, which compounds the issue of trust.

- **Interfaces:** While the systems assessed support a blend of real-time and batch interfaces, many rely on point-to-point transfers of files with unique file formats that are generated using custom code.

- **System Functionality:** Many of the key systems assessed are structured in a way that embeds business logic/rules and workflow into the systems code. This architecture makes it a challenge to respond quickly and efficiently to the changing needs of MLTC and the programs it manages. In addition, this limits the opportunities to utilize common functions across systems and programs.

4.2. As Is Technical Architecture

This section summarizes the results of the As-Is TA assessment of the Nebraska Medicaid Enterprise. Nebraska assessed the following major systems as part of the TA:

- MMIS
- N-FOCUS/ACCESSNebraska
- CONNECT
- Provider Information and Enrollment Website
- MDR
- Trading Partner Application Database
- KoDak/Prior Authorization
- Casemix
- NMES
- N-FOCUS VRU

The results for each information capability for the assessed systems 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 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 methods provided in the *CMS MITA Framework 3.0 Companion Guide* were used to determine the TA capability maturity for each system. The Guide states:

> *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.).*

For the complete set of technical scoring results, see Appendix D: Technical Supporting Results.

4.2.1. Maturity Level Profile

Figure 17 illustrates the As-Is MITA maturity level for the technical functions in the TA. As illustrated, all technical functions are presently at either a Level 1 or 2. MLTC's intent is to steadily improve the MITA maturity levels for the technical functions over the next six years.

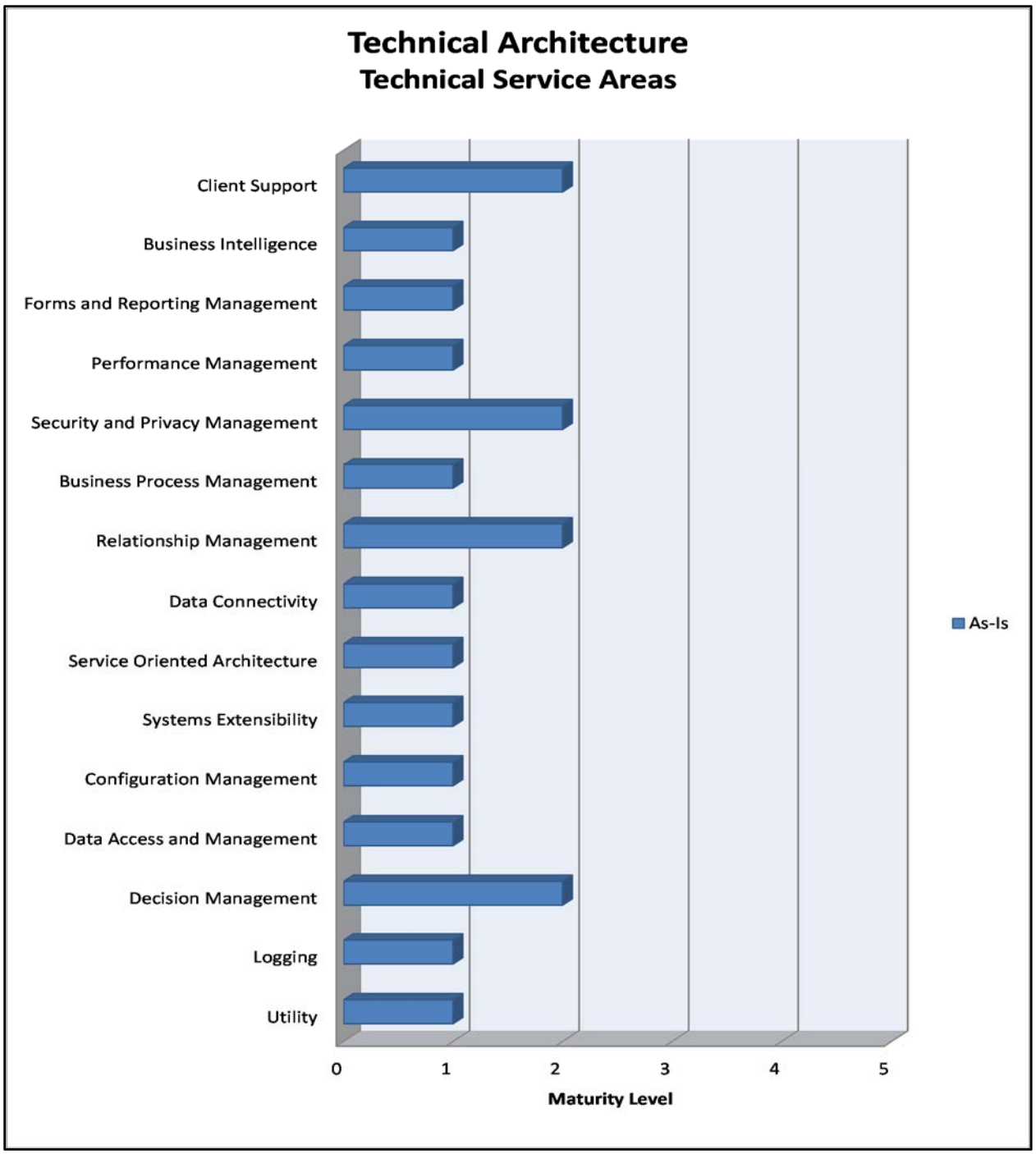
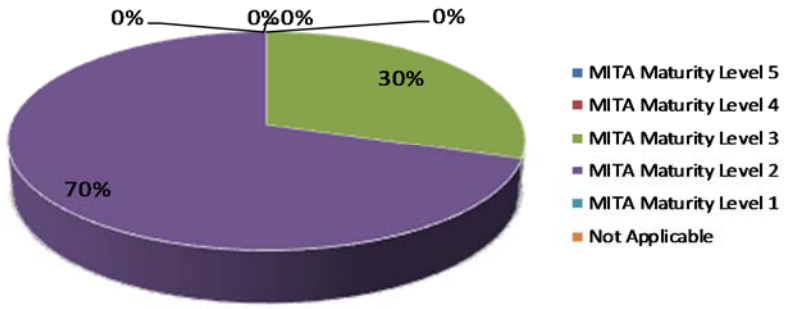


Figure 17 - Technical Architecture Maturity Assessment Results

4.2.2. Client Support

MITA Technical Function and Description	NE Medicaid Systems	
Client Support	**System**	**As-Is**
The Client Support technical function focuses on the ability to access business functions using a single web-enabled access point. ***Level 1:*** *Beneficiary and provider access to appropriate business functions via manual or alphanumeric devices.* ***Level 2:*** *Beneficiary and provider access to appropriate business functions via portal with single online access point.* ***Level 3:*** *Beneficiary and provider access to appropriate business functions via portal with single online access point including standard exchanges.* ***Level 4:*** *Beneficiary, provider and other staff access beneficiary electronic health data online including clinical data. Data exchanged with HIE. Beneficiary access to HIX.* ***Level 5:*** *National exchange of beneficiary, provider, and other appropriate data. National data exchanged with HIE. Cross-region Member access to HIX.* ***0:*** *Not Applicable*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	3
	Provider Information/ Enrollment Website	2
	NMES (AVRS)	2
	VRU	2
	MDR	3
	Trading Partner Application database	2
	KoDak Prior Authorization	2
	Casemix	3

As-Is



As-Is Client Support Assessment

The Client Support technical function is applicable to all of the Medicaid systems assessed. Of these systems, 30% are operating at maturity level 3, which means that users access the system through a single on-line portal. The remaining 70% of systems assessed are at Level 2 because access is provided by a traditional (non-portal) on-line user interface.

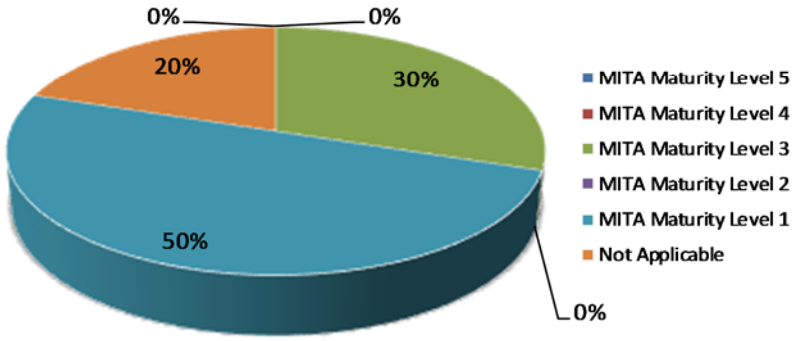
Notes:

- CONNECT TA Client Support was rated as a 3 because the system implemented an OBIEE architecture and is supported in all browser types.
- MDR and Casemix are rated a 3 for Client Support because they are coded in MS .NET and use Active Directory Authentication
- MMIS, N-FOCUS/ACCESSNebraska, Provider Information/and Enrollment Website, NMES, VRU, Trading Partnet App DB and KoDak are all rated a 2 because these systems have a single on-line access point and no ability for the user to customize or adjust their access point presentation view.

4.2.3. Business Intelligence

MITA Technical Function and Description	NE Medicaid Systems	
Business Intelligence	**System**	**As-Is**
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 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*	MMIS (includes MC)	3
	N-FOCUS/ACCESSNebraska	3
	CONNECT	3
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	1
	VRU	0
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



As-Is Business Intelligence Assessment

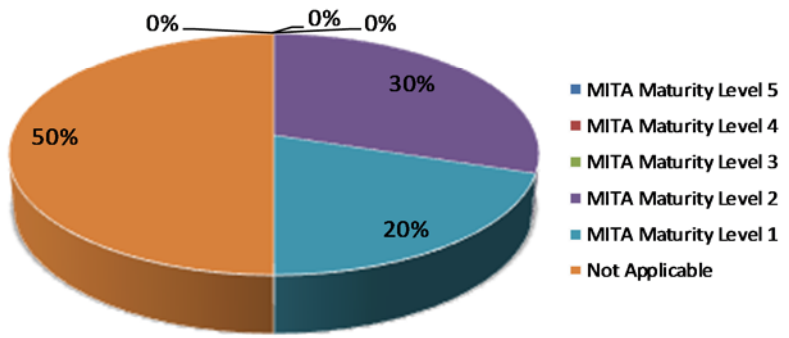
The Business Intelligence technical function applies to 80% of the systems assessed. Of those systems assessed approximately 38% were rated at level 3, with the remaining 62% of systems being assessed at level 1. As a result, for the systems assessed, the business intelligence information is either captured through custom coding or made available to specific system users.

Notes:
MMIS, N-FOCUS/ACCESSNebraska, and CONNECT are rated a 3 for Business Intelligence because the information is available for a small group of stakeholders for certain business functions via system specific solutions (i.e. Truven, OBIEE, Shadow database).

4.2.4. Forms and Reporting Management

MITA Technical Function and Description	NE Medicaid Systems	
Forms and Reporting Management	**System**	**As-Is**
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 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:*** The SMA adopts *real-time national database with regional, state, and local reporting information.* ***0:*** *Not Applicable*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	0
	VRU	0
	MDR	0
	Trading Partner Application database	1
	KoDak Prior Authorization	0
	Casemix	0

As-Is



As-Is Forms and Reporting Management Assessment

The applicability of the Forms and Reporting Management technical function varies across the Medicaid systems included in Nebraska's assessment. Based on our assessment, this technical function applies to half of the systems assessed. Of those, 60% are at level 2 because they take advantage of electronic forms. The remaining 40% of systems were rated at level 1 due to a reliance, in part, on entry from paper forms.

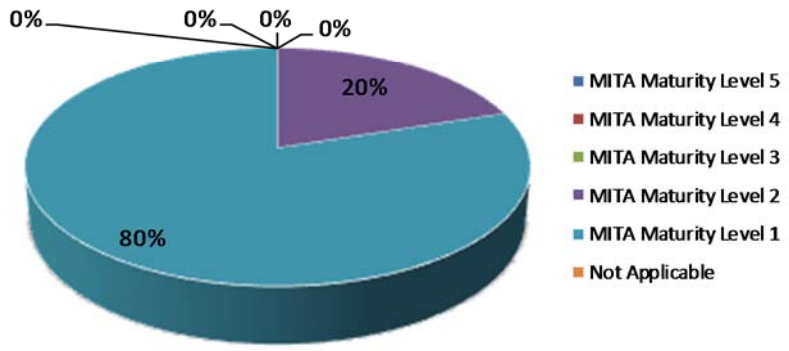
Notes:

• MMIS, N-FOCUS/ACCESSNebraska, and CONNECT where scored a 2 (as opposed to level 3) for Forms and Reporting Management because the systems generate forms in PDF format for manual application data entry.

4.2.5. Performance Measurement

MITA Technical Function and Description	NE Medicaid Systems	
Performance Measurement	**System**	**As-Is**
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*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	1
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	2
	VRU	2
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



As-Is Performance Measurement Assessment

The Performance Measurement technical function was found to be applicable to all the systems included in the assessment. The method used varied across the systems assessed, with 20% meeting level 2 through the use of performance standards set by the State and pre-defined reporting capabilities. The remaining 80% were rated as level 1 due to the use of a combination of automated and manual calculations.

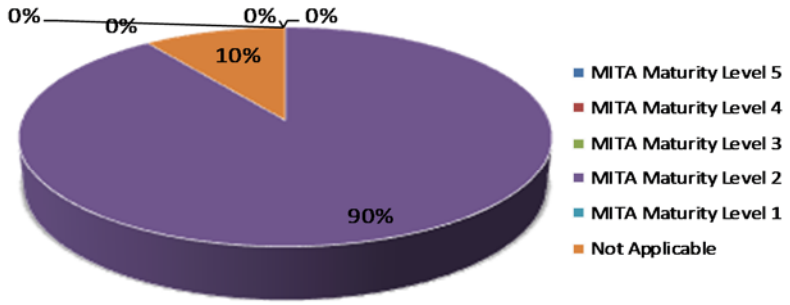
Notes:

- The VRU and NMES (voice response systems) are rated a 2 for Performance Measurement because they capture and track call statistics.

4.2.6. Security and Privacy

MITA Technical Function and Description	NE Medicaid Systems	
Security and Privacy	**System**	**As-Is**
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 beneficiary and provider access to services via browser, kiosk, voice response system, or mobile phone.* ***Level 3:*** *Provides beneficiary 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*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	2
	VRU	2
	MDR	2
	Trading Partner Application database	2
	KoDak Prior Authorization	2
	Casemix	2

As-Is



As-Is Security and Privacy Assessment

The Security and Privacy technical function is rated at a level 2 in all of the Nebraska Medicaid systems assessed where applicable. The multi-channel access supported by most of the systems provides the ability for secure logon, while making access widely available to users.

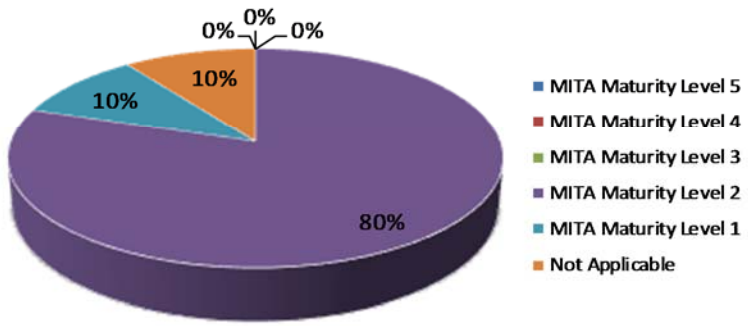
Notes:

- MDR and Casemix are rated a 2 for Security and Privacy because they use the MS.NET framework that provides numerous techniques for secured web applications.
- N-FOCUS/ACCESSNebraska are scored a 2 for Security and Privacy because the use of common external action blocks (mainframe) and Web-stored procedures lists are used for security.
- MMIS, N-FOCUS, Trading Partner Application database, and KoDak are rated a 2 for Security and Privacy because these systems utilize a unique user ID using several different levels of security. Resource Access Control Facility (RACF) security software is used to provide access to DB2 tables, flat files, CICS, TSO and application software.
- NMES and VRU are rated a 2 for Security and Privacy because they allow user access through these voice response unit systems.

4.2.7. Business Process Management

MITA Technical Function and Description	NE Medicaid Systems	
Business Process Management	**System**	**As-Is**
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 operations and requirements.* ***Level 3:*** *Specifications 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 MITA Maturity Model 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*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	2
	VRU	2
	MDR	2
	Trading Partner Application database	2
	KoDak Prior Authorization	1
	Casemix	2

As-Is



As-Is Business Process Management Assessment

The Business Process Management technical function was found to be applicable to 90% of the systems included in the scope of the assessment, and all but one of the systems was rated as a MITA level 2. This means that, for 89% of systems assessed, a mix of manual and automated processes are used to support State and federal program requirements. The remaining system utilizes a predominantly paper based process, and is rated at MITA level 1.

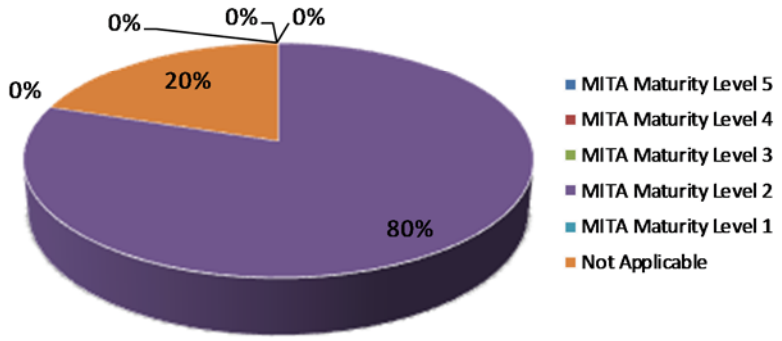
Notes:

- N-FOCUS/ACCESSNebraska are scored a 2 for Business Process Management because of their use of the expert system (Aion Rules Engine) to store rules for automatic business processes. Additionally they use workflows provided by CMS in support of the Medicaid business (FDSH, etc.)
- MMIS, Trading Partner Application database, NMES, VRU, MDR, Casemix, and CONNECT are scored at a 2 for Business Process Management because they use a mix of manual and automatic business processes.

4.2.8. Relationship Management

MITA Technical Function and Description	NE Medicaid Systems	
Relationship Management	**System**	**As-Is**
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:*** *The SMA applies a mix of HIPAA and state-specific standards for service support.* ***Level 3:*** *Basic Business Relationship Management (BRM), including tracking relationships between system users (e.g., members and providers) and that 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*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	2
	VRU	2
	MDR	2
	Trading Partner Application database	2
	KoDak Prior Authorization	0
	Casemix	2

As-Is



As-Is Relationship Management Assessment

The Relationship Management technical function is applicable to 80% of the Medicaid systems included in the assessment and all of them were rated as a MITA level 2. As a result, some business relationship management occurs, but is not standardized. The analytics, assessment, and improvements to these relationships are fragmented and difficult to track and measure.

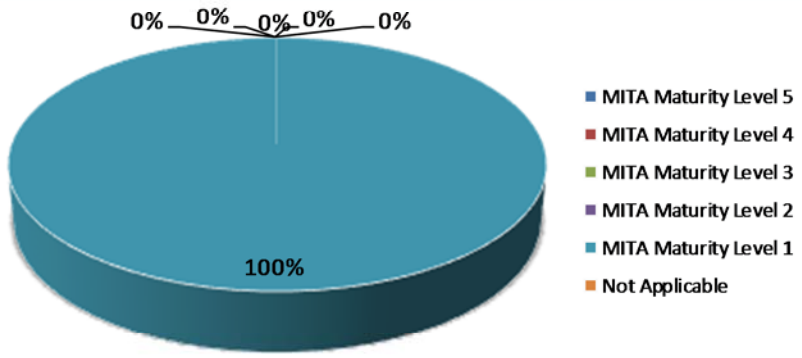
Notes:

• MMIS, N-FOCUS/ACCESSNebraska, CONNECT, NMES, VRU, MDR, Trading Partner Application database, and Casemix are all rated a 2 for Relationship Management because their systems apply a mix of State-specific standards between Medicaid system users and the services requested and received.

4.2.9. Data Connectivity

MITA Technical Function and Description	NE Medicaid Systems	
Data Connectivity	**System**	**As-Is**
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 non-standard formats and in various media (e.g., paper , facsimile, Electronic Data Interchange (EDI)).* ***Level 2:*** *Electronic data 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:*** *Electronic data 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*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	1
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	1
	VRU	1
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



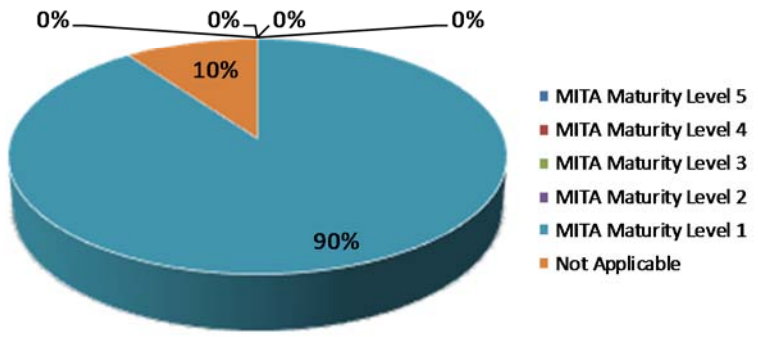
As-Is Data Connectivity Assessment

The Data Connectivity technical function is applicable to all the Medicaid systems included in the assessment, and is rated at a MITA level 1. While all of the systems assessed exchange information electronically between multiple systems and organizations, it is done through point to point exchanges as opposed to the use of an information hub. In addition, data sharing between internal and external systems continues to rely heavily on batch file transfers as opposed to transaction-based interfaces.

4.2.10. Service Oriented Architecture

MITA Technical Function and Description	NE Medicaid Systems	
Service Oriented Architecture	**System**	**As-Is**
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 Healthcare 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 System Development Life Cycle (SLDC) for Healthcare Enterprise. Interoperable outside of HHS, interstate, and other healthcare stakeholders, such as, HIE or HIX.* ***Level 5:*** *MITA compliant ESB, use of SOA and SDLC for Healthcare Enterprise. Interoperable extends to federal agencies.* ***0:*** *Not Applicable*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	1
	CONNECT	1
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	1
	VRU	1
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



As-Is Service Oriented Architecture Assessment

The SOA technical function is applicable to 90% of the Medicaid systems included in the scope of the Nebraska assessment. All of the systems use procedural code to orchestrate their business processing and functions, as opposed to using either messaging or services. Therefore, all systems assessed were determined to be at MITA level 1.

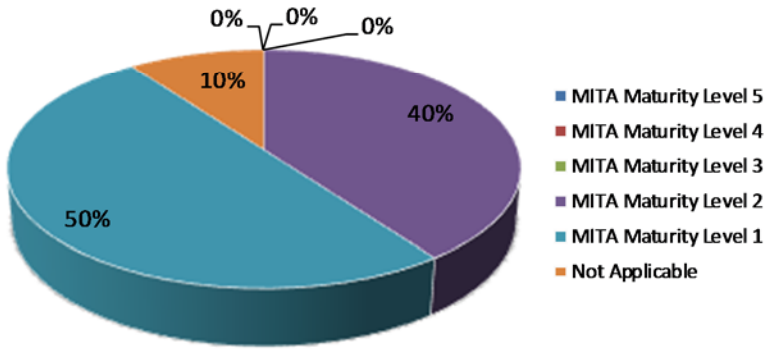
Notes:

- None of the NE Medicaid systems within this scope use SOA and therefore are all rated a 1.

4.2.11. System Extensibility

MITA Technical Function and Description	NE Medicaid Systems	
System Extensibility	**System**	**As-Is**
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 RESTful and/or SOAP-based web services for seamless coordination and integration with other U.S. Department of Health & Human Services (HHS) applications and intrastate agencies including the HIX.* ***Level 4:*** *Supports RESTful and SOAP-based web services with interstate agencies including Health Information Organizations (HIO) 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 services capability. The SMA adopts full usage of NwHIN with exposed services to all appropriate parties.* ***0:*** *Not Applicable*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	1
	VRU	1
	MDR	2
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	2

As-Is



As-Is System Extensibility Assessment

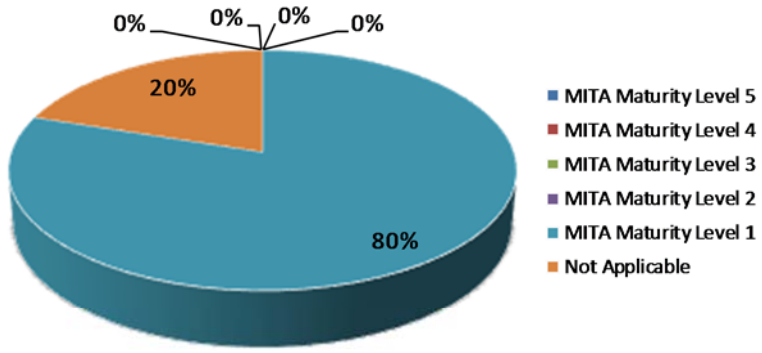
The Systems Extensibility technical function applies to 90% of the systems included in the scope of the assessment, and all are rated as either MITA level 1 or level 2. While some of the systems assessed MITA level 2 use web services to some degree, all of the systems still rely on extensive code changes to modify or extend system functionality.

Notes:
- CONNECT System Extensibility is rated a 2 because it uses Intelli-Ride web services in real-time.
- N-FOCUS / ACCESSNebraska is rated a 2 because it uses web services in real-time with the Federal Data Services Hub.

4.2.12. Configuration Management

MITA Technical Function and Description	NE Medicaid Systems	
Configuration Management	**System**	**As-Is**
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 Environmental Management through the SDLC. Development process between intrastate and interstate agencies, federal entities and external health care stakeholders.* ***0:*** *Not Applicable*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	1
	CONNECT	1
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	1
	VRU	1
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	0
	Casemix	1

As-Is



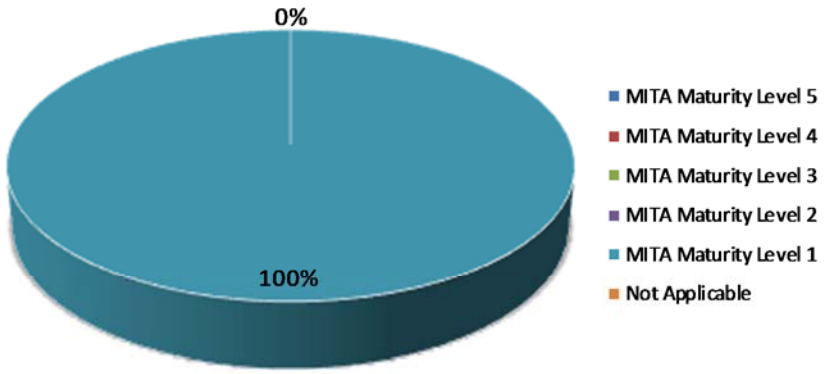
As-Is Configuration Management Assessment

The Configuration Management technical function is currently rated at MITA maturity level 1 for 80% of the Medicaid systems in the assessment where the function applies. At present, all of the systems assessed are to some degree dependent on characteristics of the underlying technology. Therefore, the introduction of new or alternate technology has the potential for significant impact on and disruption to the systems.

4.2.13. Data Access and Management

MITA Technical Function and Description	NE Medicaid Systems	
Data Access and Management	**System**	**As-Is**
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. Adhoc, point-to-point approaches to systems integration. No use of enterprise-side 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 or 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 electronic health records.* ***0:*** *Not Applicable*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	1
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	1
	VRU	1
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



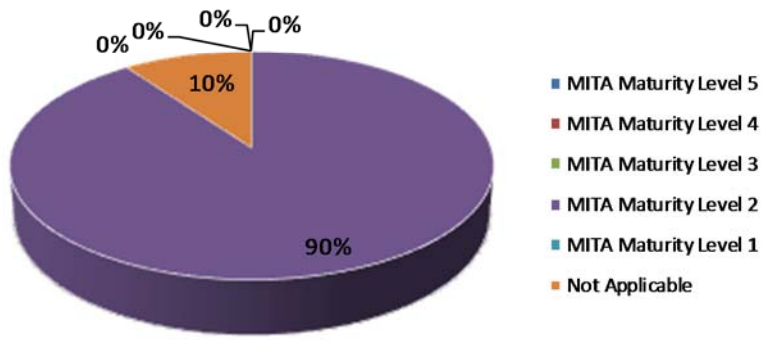
As-Is Data Access and Management Assessment

The Data Access and Management technical function applies to all of the systems included in the assessment, and all of them are rated as a MITA level 1 This means that the systems have data schemas that are unique and data exchanges are done in a non-standard and point-to-point fashion.

4.2.14. Decision Management

MITA Technical Function and Description	NE Medicaid Systems	
Decision Management	**System**	**As-Is**
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 of 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*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	2
	VRU	2
	MDR	2
	Trading Partner Application database	2
	KoDak Prior Authorization	2
	Casemix	2

As-Is



As-Is Decision Management Assessment

The Decision Management technical function is rated at a MITA level 2 for 90% of the Medicaid systems included in the assessment where the function is applicable. While one of the systems (N-FOCUS) utilizes an inference engine to support some of its functions, it and all of the other systems assessed imbed business rules in their core application code.

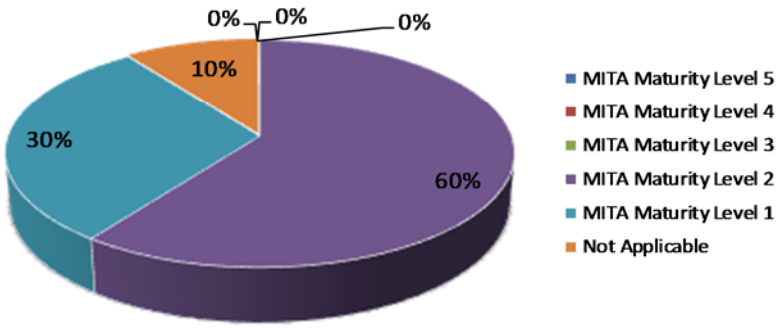
Notes:

- N-FOCUS utilizes Aion to support some business rules, but also implements business rules as part of its core application code.

4.2.15. Logging

MITA Technical Function and Description	NE Medicaid Systems	
Logging	**System**	**As-Is**
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 disapproval 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*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	1
	VRU	1
	MDR	2
	Trading Partner Application database	2
	KoDak Prior Authorization	1
	Casemix	2

As-Is



As-Is Logging Assessment

The Logging technical function is applicable to 90% of the systems included in the assessment. Two-thirds of the systems assessed were rated MITA level 2, while the remaining third were rated at level 1. All of the systems utilize logon ID and password to ensure only authorized parties are able to access the system. Those systems rated level 2 have also implemented capabilities to log the actions of users once they have accessed the system. These logs allow systems administrators and security personnel to review historical events including logon approvals and disapprovals.

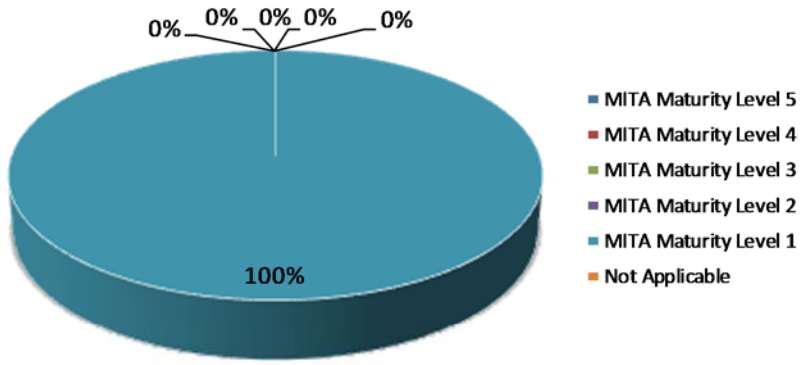
Notes:

• Many of the systems have some of the level 3 characteristics (role-based access, PKI, etc.) but none fully satisfy them all, and therefore are rated level 2.

4.2.16. Utility

MITA Technical Function and Description	NE Medicaid Systems	
Utility	**System**	**As-Is**
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 stream processing to optimize service offering.* ***0:*** *Not Applicable*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	1
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	1
	VRU	1
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



As-Is Utility Assessment

The Utility technical function is rated as a MITA level 1 for all of the Medicaid systems in the scope of this assessment. While a number of the systems assessed meet some of the characteristics of level 2 and/or level 3, none of them meet all of the criteria and are therefore rated level 1. Some of the level 2 and level 3 characteristics supported use a set of computer programs to perform unique business and technical tasks, integration of multiple applications, and use of SDLC governance activities.

4.3. As Is Information Architecture

This section summarizes the results of the As-Is IA assessment of the Nebraska Medicaid enterprise. Nebraska assessed the following major systems as part of the IA:

- MMIS
- N-FOCUS/ACCESSNebraska
- CONNECT
- Provider Information and Enrollment Website
- MDR
- Trading Partner Application Database
- KoDak Prior Authorization
- Casemix

Note: This portion of the MITA assessment focuses predominately on the processes, standards, and methods related to the management of business information in the Medicaid enterprise. Therefore, systems that do not store or operate directly on business data were excluded from the assessment, and in keeping with the MITA 3.0 scoring methodology, were assigned a score of 0. There were two systems that fell into this category, the Nebraska Medicaid Eligibility System (NMES), which is the automated voice response system that supports MMIS, and the automated voice response unit that supports N-FOCUS/ACCESSNebraska. These systems are included in the TA assessment since they influence the performance and capabilities of the systems they support.

The information capability results for the assessed systems 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 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 methods provided in the CMS MITA Framework 3.0 Companion Guide were used to determine the information architecture capability maturity for each system. The guidance is as follows:

> *"The SMA must meet all the capabilities for a level before it can advance to the next level when evaluating the IA. A business area scores at a Level 3 only when the SMA achieves all information capabilities defined for Level 3 in the ICM. 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.)."*

4.3.1. Maturity Level Profile

Figure 18 illustrates the As-Is MITA maturity level for the Information Capabilities in the IA. As illustrated, all four capabilities are at Level 1.

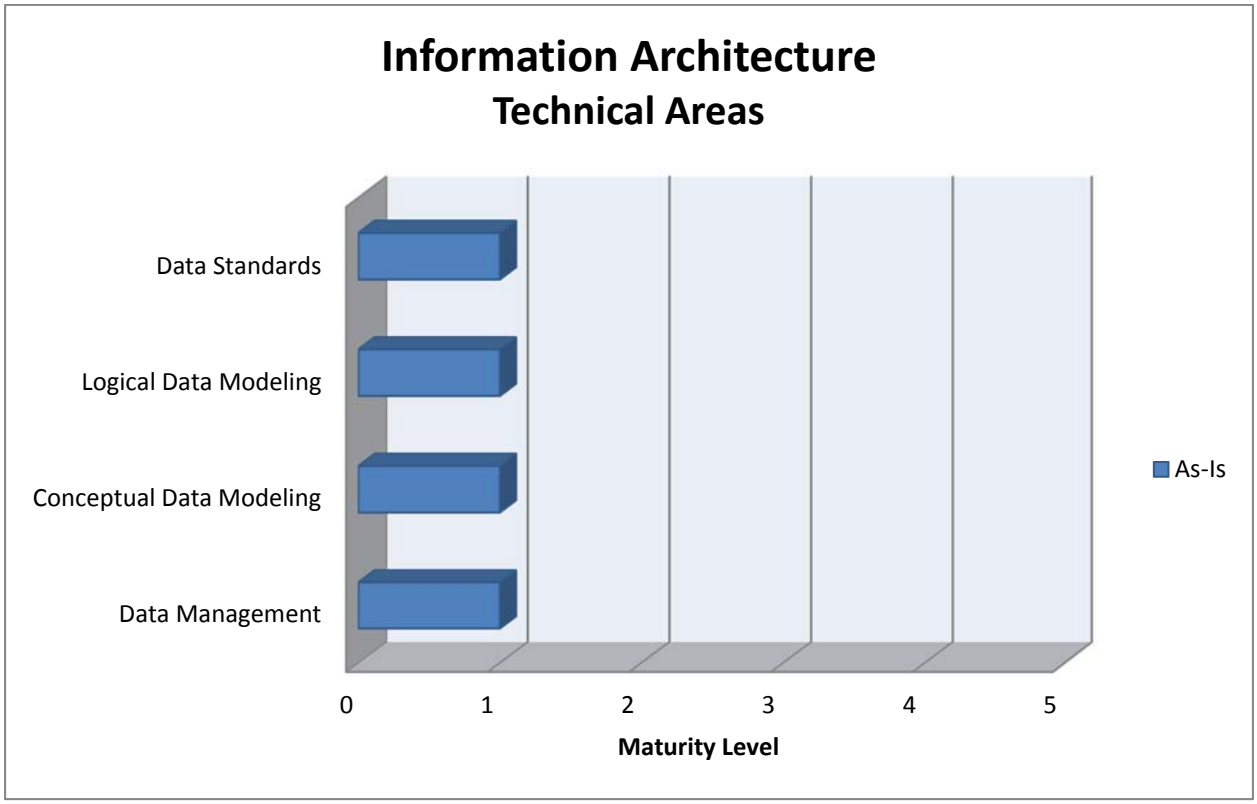


Figure 18 - Information Architecture Technical Areas

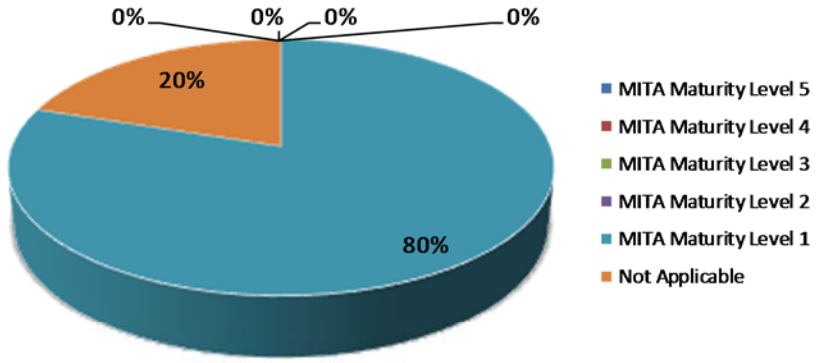
Overall, the Medicaid Enterprise's As-Is IA has a level one maturity in the four areas. However, not all business processes and systems score a level one maturity in the four areas. Details relating to the score by business process and business are included in Appendix D.

Sections 4.3.2 through 4.3.8 contain the Information Capability Maturity Levels for each of the systems referenced in Section 4.3. The results are displayed in a table and graphical format. The capability description introduction for each section is contained in the actual table.

4.3.1.1. Data Governance

MITA Information Capability and Description	NE Medicaid Systems	
Data Management Strategy: Data Governance	**System**	**As-Is**
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. For Data Governance: ***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*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	1
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	0
	VRU	0
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



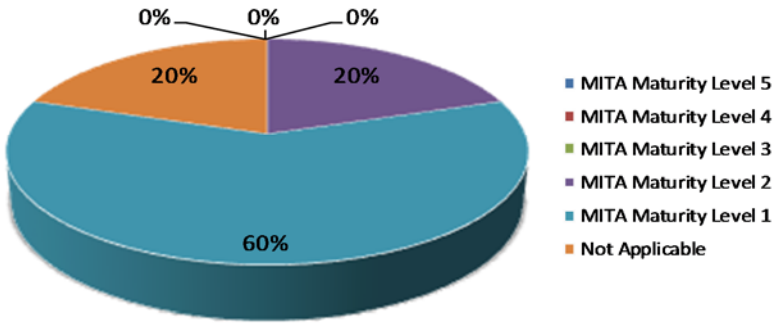
As-Is Data Management Strategy: Data Governance Assessment

The Data Governance information function was found to be applicable to 80% of the Medicaid systems included in the scope of the assessment. All of the applicable systems were rated as a MITA level 1. Most of the systems assessed have some degree of data governance in place that is executed by the technical staff, and some have governance activities that incorporate the business. In all cases, the scope of the data governance activities were specific to the system assessed, which limited the ratings.

4.3.1.2. Enterprise Data Architecture

MITA Information Capability and Description	NE Medicaid Systems	
Data Management Strategy: Data Architecture	**System**	**As-Is**
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. For Enterprise Data Architecture: 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 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	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	0
	VRU	0
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



As-Is Data Management Strategy: Data Architecture Assessment

The Enterprise Data Architecture information is applicable to 80% of the Medicaid systems included in the assessment. The majority of the systems (75%) assessed were found to be at MITA level 1 due to limited standardization of the data architecure development methodology. The remaining 25% of the systems were assessed at level 2. These systems utilize a systems development methodology that includes standard methods for the identification, definition, and development of systems data.

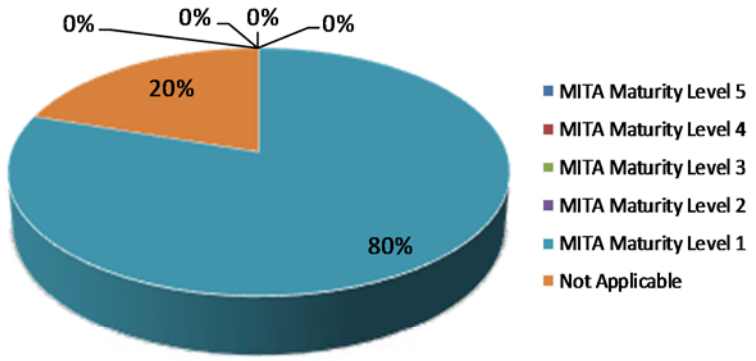
Notes:

- Both MMIS and N-FOCUS/ACCESSNebraska follow a formal SDLC procedure that define roles and documentation for data.
- MMIS, N-FOCUS/ACCESSNebraska, CONNECT, MDR, Trading Partner Application database and Casemix have physical data models that define their systems data structures, data entities, attributes, and relationships, which efficiently describe Medicaid data used within those systems.

4.3.1.3. Enterprise Modeling

MITA Information Capability and Description	NE Medicaid Systems	
Data Management Strategy: Enterprise Modeling	**System**	**As-Is**
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. For Enterprise Modeling: ***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 sources 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 knowledge.* ***0:*** *Not Applicable*	MMIS (includes MC)	1
	N-FOCUS/ACCESSNebraska	1
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	0
	VRU	0
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



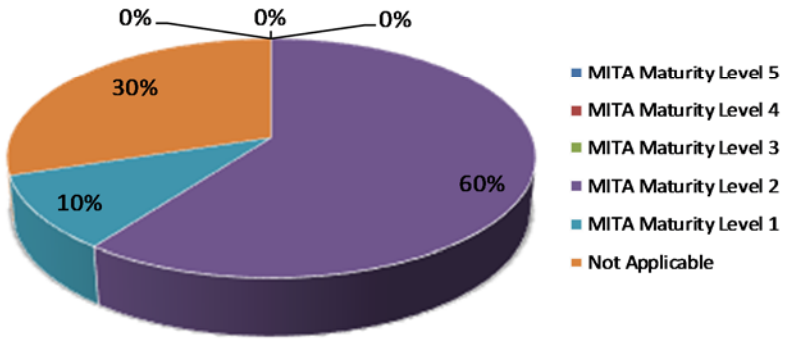
As-Is Data Management Strategy: Enterprise Modeling Assessment

The Enterprise Modeling information function is applicable to 80% of the systems included in the scope of the Nebraska assessment. Most of the systems assessed utilize data modeling as part of their systems development methodology, although the processes and models vary by system. For that reason, all of the systems have been rated as MITA level 1.

4.3.1.4. Data Sharing Architectures

MITA Information Capability and Description	NE Medicaid Systems	
Data Management Strategy: Data Sharing Architectures	**System**	**As-Is**
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. For Data Sharing Architectures: ***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*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	0
	NMES (AVRS)	0
	VRU	0
	MDR	2
	Trading Partner Application database	2
	KoDak Prior Authorization	1
	Casemix	2

As-Is



As-Is Data Management Strategy: Data Sharing Architectures Assessment

The Enterprise Data Sharing Architectures apply to 70% of the systems included in the scope of this assessment. All but one (85%) of the systems assessed is rated as a MITA level 2. This means that, for those systems, the data sharing architecture is unique to that system's interfaces and that data sharing is done on an ad hoc, point-to-point fashion.

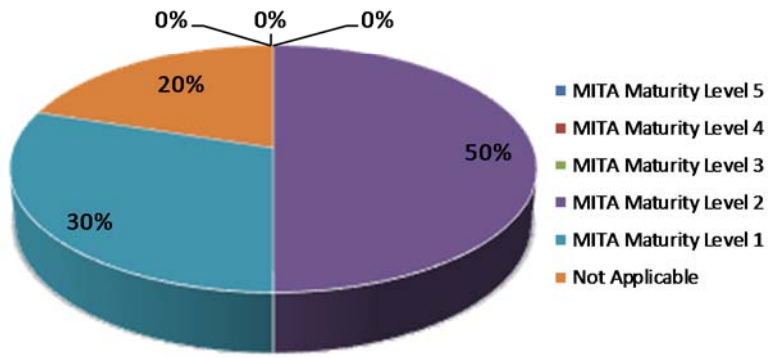
Notes:

• MMIS, N-FOCUS/ACCESSNebraska, CONNECT, MDR, Trading Partner Application database and Casemix have physical data models that define their system's data structures, data entities, attributes, and relationships, which efficiently describe Medicaid data used within those systems

4.3.1.5. Conceptual Data Model

MITA Information Capability and Description	NE Medicaid Systems	
Conceptual Data Model	**System**	**As-Is**
The Conceptual Data Model (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*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	0
	VRU	0
	MDR	2
	Trading Partner Application database	2
	KoDak Prior Authorization	1
	Casemix	2

As-Is



As-Is Conceptual Data Model Assessment

The CDM information function is applicable to 80% of the Medicaid systems included in this assessment. For all of the systems assessed, it was determined that the MITA maturity was either level 1 (37%) or level 2 (63%). This means that the CDM for these systems is either non-existent or is documented in a non-standard format.

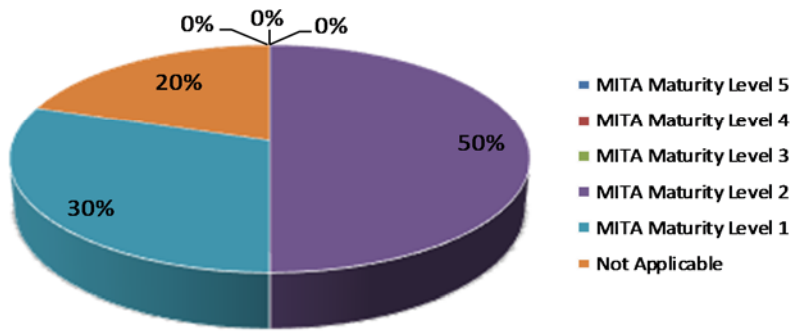
Notes:

• MMIS, N-FOCUS/ACCESSNebraska, MDR, Trading Partner Application database and Casemix CDM were rated a 2 because their use of MS Visio and other data modeling tools (e.g., CA GEN CASE tool) to create high level data model representations of high level data and relationships is documented.

4.3.1.6. Logical Data Model

MITA Information Capability and Description	NE Medicaid Systems	
Logical Data Model	**System**	**As-Is**
The Logical Data Model (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 the data classes, attributes, relationships, standards, and code sets for regional exchange including clinical information.* ***Level 5:*** *LDM identifies the data classes, attributes, relationships, standards, and code sets for national exchange.* ***0:*** *Not Applicable*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	2
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	0
	VRU	0
	MDR	2
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	2

As-Is



As-Is Logical Data Model Assessment

The LDM information function is applicable to 80% of the Medicaid systems included in this assessment. For all of the systems assessed, it was determined that the MITA maturity was either level 1 (37%) or level 2 (63%). This means that the LDM for these systems is either non-existent or is documented in a non-standard format.

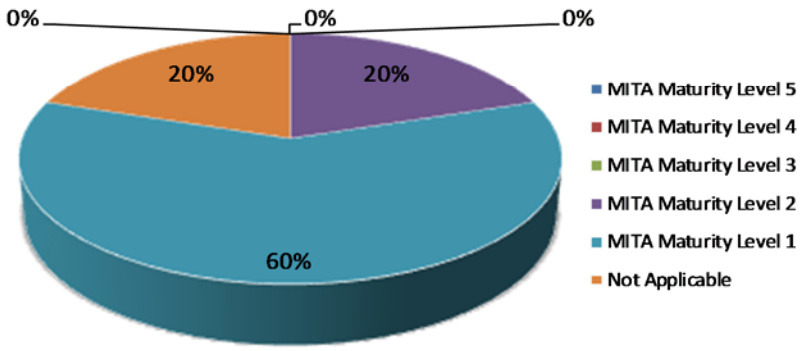
Notes:

- For CONNECT, and N-FOCUS/ACCESSNebraska, the LDM was scored a value because they use object models with a set of classes that model both the data and the methods associated with the business functions.
- MMIS, MDR, and Casemix are rated a 2 for LDM because they use DB2 and/or SQL Server 2008 to construct the LDM after all the business entities are identified in the scope of the application.

4.3.1.7. Data Standards

MITA Information Capability and Description	NE Medicaid Systems	
Data Standards	**System**	**As-Is**
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 standardized 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*	MMIS (includes MC)	2
	N-FOCUS/ACCESSNebraska	2
	CONNECT	1
	Provider Information/ Enrollment Website	1
	NMES (AVRS)	0
	VRU	0
	MDR	1
	Trading Partner Application database	1
	KoDak Prior Authorization	1
	Casemix	1

As-Is



As-Is Data Standards Assessment

The Data Standards information function is applicable to 80% of the Medicaid systems included in the assessment. Of those systems assessed, 25% were determined to be MITA level 2, with the remaining 75% coming in at level 1. As a result, data standards are implemented in either non-standard or system-specific fashion, and therefore do not act as aenterprise standards.

Notes:

- MMIS Data Standards was scored a 2 because the system uses SQL standards and guidelines.
- N-FOCUS/ACCESSNebraska was rated a 2 for Data Standards because standard physical abbreviations are assigned by the DBAs and used for systems entities and attributes.

5. Business, Information, and Technical Architecture Recommendations

The recommendations in this section all underscore the point that in order for Nebraska to continue and accelerate Medicaid transformation, it must view and govern the agency as a business enterprise of interconnected processes. These processes must support one another to achieve a mutual set of goals, rather than be a collection of business functions focused on the completion of administrative tasks. MLTC is well under way to realizing this transformation through the ongoing acquisition and implementation of MITA-aligned major technology projects.

Enterprise-wide themes that recur throughout this section include recommendations for unified, standardized data management and governance, development and maintenance of SOPs, implementation of MITA-aligned performance measurement and reporting, and adoption of standard methods for modeling systems and data in coordination with SDLC management. Additionally the SMA intends to leverage the capabilities and functions of its new systems (when implemented) to enhance alignment with MITA framework and adoption of the SSC.

All of these initiatives are detailed in the MITA Roadmap in Section 7.

5.1. Modularity Standard

The Modularity standard requires the use of a modular, flexible approach to systems development, including the use of open interfaces and exposed application program interfaces (API); the separation of standardized business rule definitions from core programming; and the availability of standardized business rule definitions in both human and machine-readable formats.[1]

5.1.1. Activities Contributing to the Standard

Currently, the SMA uses proprietary business process methodologies. For example, Eligibility Operations uses a basic flowcharting method for process diagrams depicting ACA compliant processes.

Currently, data, data management, and data governance are not standardized across the enterprise. Most individual systems, however, do conform to a set of data standards unique to its individual system. Interactions between systems rely on a variety of interfaces, both standard and non-standard.

[1] SS-A Appendix A – Seven Standards and Conditions 3.0, CMS, February 2012, Version 3.0.

Business rule definitions are not standardized, and implementation of business rule changes requires extensive coding changes. These factors limit advances to higher levels of maturity.

Currently, the SMA is implementing several initiatives that will have a substantial impact on modularity. These include:

- EES – This project will replace the Medicaid eligibility and enrollment functions of the State's legacy system. Alignment with the MITA framework and the SSC are key requirements for implementation. Communication and coordination among MLTC, its clients, and other stakeholders will be significantly enhanced.
- MMIS replacement – This project will replace the legacy MMIS, enabling uniform and standardized automation of Medicaid claims processes. Alignment with the MITA framework and the SSC are also key requirements of this initiative.

5.1.2. Recommendations

Department leadership should consider a modular approach for continued management of the Medicaid Transformation. This approach is implicit in the MITA Framework, which includes ten business areas comprised of business processes, across three architectures. From a modular perspective, the Enterprise and its component business areas can benefit from the use (and re-use) of standardized business rules, interfaces, and performance measurement and management processes. This approach can encompass systems procurement/development, business process management, and data sharing across organizations, both internal and external to the SMA.

5.1.2.1. Business Architecture

- *SOPs and processes across the enterprise*: Taking a process view instead of a program view will allow for reuse across the enterprise. For example, eligibility determination is the same basic process but business rules often differ by program (i.e., Balanced Incentive Program, Program of All-Inclusive Care for the Elderly, and Medicaid).
- *Solutions that support a modular approach to business processes:* Procuring and/or developing systems and solutions that support a modular approach will enable the easier replacement or addition of certain functionality, possibly reducing the need to replace whole systems.
- *Workflow strategy:* Investing in a comprehensive workflow strategy across all business areas will help standardize business processes.

5.1.2.2. Information Architecture

- *Data management strategy:* Creating standard policies for the exchange of data between systems will facilitate that exchange and ensure that the shared data can be trusted and used for program improvements.

- *Data management policy development:* Requiring policies that mandate industry standard data exchange formats for future interface development. Established policies should also support a modular-based EA. Data should reside in the system of record, and systems that need information from the system of record should be able to request and receive it on a real-time basis.
- *Data governance:* Establishing an implementation review process to verify that system development efforts are in compliance with established policies will ensure that systems are developed on time and within budget.

5.1.2.3. Technical Architecture

- *Embrace SOA:* Using SOA is a fundamental component in reaching a Level 3 MITA maturity level. An important outcome of SOA is the ability to replace system components, or modules, when business needs require new capabilities. The SMA will keep in mind this key concept as it considers alternative solutions to replace or enhance current business systems.
- *Establish rules engine capabilities:* Using a business rules engine can allow system changes to be made more efficiently by adjusting business rules rather than changing programming logic. Ideally, the efficiencies gained would allow the SMA to be more responsive to changes in the business environment, which is as an essential component to a more flexible enterprise.

5.2. MITA Condition

The MITA condition requires states to align to and advance increasingly in MITA maturity for business, architecture, and data. CMS expects states to prepare and continue to make measurable progress in implementing their MITA roadmaps. [2]

5.2.1. Activities Contributing to the Standard

As part of the 2014 MITA 3.0 SS-A, the SMA is conducting a MITA 3.0 assessment and plans to maintain this documentation for any required annual submission to CMS. Part of this effort includes a MITA Roadmap, a Concept of Operations (COO), and a Business Process Model (BPM). As additional guidance on the COO and BPM are released by CMS, Nebraska will use these guidelines.

Currently, the SMA is engaged in preparing and implementing a SS-A Maintenance Plan. This plan will establish a process for MLTC to support ongoing maintenance and annual updates of the

[2] SS-A Appendix A – Seven Standards and Conditions 3.0, CMS, February 2012, Version 3.0.

MITA Roadmap and the overall SS-A; it is expected that this process will speed improvement of the State's MITA Condition.

5.2.2. Recommendations

Department leadership should continue to align to and advance in MITA maturity by implementing the MITA Roadmap, performing annual updates to the SS-A, and continuing with governance as documented in the annual SS-A update process.

5.2.2.1. Business Architecture

- *SS-A maintenance process:* Continue to update the SS-A, the MITA Roadmap, and the COO. Continue to utilize the SS-A as a benchmark for process improvement across the enterprise.
- *Business process modeling development:* Identify and adopt national/industry standard business process modeling methodology (e.g., BPMN) to support process improvement and system development.

5.2.2.2. Information Architecture

- *SS-A maintenance process:* Continue to update the SS-A, the MITA Roadmap, and the COO. Continue to utilize the SS-A as a benchmark for process improvement across the enterprise.
- *Standardized data modeling practices:* Begin development of a conceptual and a logical data model.

5.2.2.3. Technical Architecture

- *SS-A maintenance process:* Continue to update the SS-A, the MITA Roadmap and the COO. Continue to utilize the SS-A as a benchmark for process improvement across the enterprise.
- *TA review practices:* Introduce formalized TA reviews into the system selection and governance processes. The TA reviews should ensure business and technology alignment, as well as alignment to MITA and CMS's SSCs.

5.3. Industry Standards Condition

- The Industry Standards condition requires states to ensure alignment with, and incorporation of, industry standards. These standards include HIPAA security, privacy, and transaction standards; accessibility standards established under Section 508 of the Rehabilitation Act that provide greater accessibility for individuals with disabilities, and

compliance with federal civil rights laws; and standards/protocols adopted by the Secretary under Sections 1104 and 1561 of the Affordable Care Act. [3]

5.3.1. Activities Contributing to the Standard

Nebraska Medicaid has adopted HIPAA/EDI standards/transactions with business partners and external entities and has partially adopted these standards for internal processes. The SMA also has adopted standards and protocols to comply with the ACA.

Currently, the SMA is engaged in implementation of several initiatives which will have a substantial impact on Modularity. These include:

- *AS-ECS* – The purpose of this project is to comply with the first set of mandated operating rules which apply to the eligibility (270/271) and claims status (277/278) HIPAA transactions. The project will be implemented in two parts, data content and connectivity. MLTC contracted with a vendor to establish the infrastructure for the connectivity and real time requirements.
- *AS-EFT/ERA* – The purpose of this project is to comply with the second set of mandated operating rules which apply to EFT and ERA transactions. The project will be implemented in two parts, data content and connectivity. MLTC will contract with a vendor to establish the infrastructure for the connectivity requirements.
- *ICD-10* – The purpose of this project is to comply with implementation of ICD-10 as mandated by the US Department of Health and Human Services (US DHHS), no later than October 1, 2015. The project will implement ICD-10 in a manner that meets or exceeds all CMS or US DHHS requirements and provides a basis for MLTC to realize the benefits of ICD-10, while mitigating operational risks.
- *T-MSIS* – The T-MSIS project is the transformation and expansion of federal reporting measures from the State's Medicaid information systems. Report data has been expanded to include eligibility information, health care quality measures, and managed care measures, in addition to medical services claims and frequency reporting.

5.3.2. Recommendations

MLTC should utilize nationally recognized standards for business analysis, requirements, and testing within intrastate agencies. These should be adopted across the enterprise regardless of size or complexity of systems development and/or maintenance projects.

[3] SS-A Appendix A – Seven Standards and Conditions 3.0, CMS, February 2012, Version 3.0.

The State should establish a uniform approach and method for incorporating industry standards in business modeling techniques (e.g., Unified Modeling Language [UML] and Business Process Model and Notation) regardless of size or complexity of the project.

5.3.2.1. Business Architecture

- *All technology project initiatives*: Identify opportunities across all projects to improve maturity levels through the adoption of industry standards, both in the method of implementation and in project management practices.
- *Uniformity of SDLC practices*: Adopt SDLC industry standards and practices for testing, acceptance, and signoff of all technology projects.

5.3.2.2. Information Architecture

As part of the Enterprise Data Management Strategy project, the expected standards to be utilized will be documented.

- *Data modeling*: Adopt a national/industry standard approach to data modeling (e.g., UML), which will support advancement of maturity level. This recommendation should be addressed during the data management and governance project.

5.3.2.3. Technical Architecture

- *TA review practices:* Introduce formalized TA reviews into the system selection and governance processes. The TA reviews should ensure consideration and adherence of applicable architecture, systems, and security standards.
- *Use of standards-based messaging:* Where applicable, adopt national/industry standard approaches to designing interfaces between systems both within the enterprise and with other agencies and entities (e.g., HIPAA X12/EDI).

5.4. Leverage Condition

State solutions should promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states. States can benefit from the experience and investments of other states through the reuse of components and technologies consistent with a service-oriented architecture, from publicly available or commercially sold components and products, and from the use of cloud technologies to share infrastructure and applications. [4]

[4] SS-A Appendix A – Seven Standards and Conditions 3.0, CMS, February 2012, Version 3.0.

5.4.1. Activities Contributing to the Standard

SMA has deployed an automated MIP solution. By supporting multiple states, this solution allows MLTC to leverage interstate development initiatives and reduce costs.

Currently, the SMA is implementing several initiatives which will have a substantial impact on the Leverage Condition. These include:

- EES – This project will replace the eligibility and enrollment functions of the State's legacy system. Alignment with the MITA framework and adoption of the SSC are key requirements for implementation. Communication and coordination between MLTC, its clients, and other stakeholders will be significantly enhanced.
- PS&E – This project will result in unified/standardized automation of provider eligibility and enrollment business processes. Alignment with the MITA framework and adoption of the SSC are key requirements for implementation. Communication and coordination between MLTC, its clients, and other stakeholders will be significantly enhanced. For example, provider applications for Medicaid participation will be fully electronic.

5.4.2. Recommendations

With the scheduled implementation of several major technology projects, the State should seek to identify opportunities for re-use of process and system components and architectures within the agency's ten business areas and in coordination with other agencies and entities.

5.4.2.1. Business Architecture

- *EES:* Identify common process and/or system functions across business areas that would benefit from exploiting the new EES architecture and services (e.g., application, verification, enrollment, communication, inquiry, and disenrollment).
- *PS&E:* Identify common process and/or system functions across business areas that would benefit from exploiting the new PS&E system architecture and services (e.g., application, verification, enrollment, communication, inquiry, and disenrollment).
- *Sources for supporting Medicaid modernization:* Leverage tools published by CMS and CMS-sanctioned interstate collaborative entities to support MITA framework alignment (e.g., Private Sector Technology Group's Medicaid Managed Care Program and Technology Toolkit).

5.4.2.2. Information Architecture

- *Inventory data assets:* During the data management and governance project, inventory existing data assets and the current data owners and stewards. Through this process, the SMA will identify duplicative data within the agency. Additionally, the SMA should establish relationships with other agencies to identify data assets of those agencies that are beneficial to the SMA and vice versa.

5.4.2.3. Technical Architecture

- *Service governance processes:* Establish a mechanism to govern the increasing number of business and technical services. A key benefit of the governance function is for developers to see what services exist, which should reduce redundancy and improve reuse.
- *TA review practices:* Introduce formalized TA reviews into the system selection and governance processes. The technical architecture reviews should include identification and consideration of opportunities for leveraging new or existing business and systems functionality.

5.5. Business Results Condition

Systems should support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, clients, and the public. [5]

5.5.1. Activities Contributing to the Standard

Currently, the SMA is engaged in implementation of several initiatives which will have a substantial impact on Business Results. These include:

- EES – This project will replace the eligibility and enrollment functions of the State's legacy system. Alignment with the MITA framework and adoption of the SSC are key requirements for implementation. Communication and coordination between MLTC, its clients, and other stakeholders will be significantly enhanced.
- MMIS replacement – This project will replace the legacy MMIS, enabling uniform and standardized automation of claims processes. Alignment with the MITA framework and adoption of the SSC are key requirements of this initiative.
- PS&E – This project will result in unified/standardized automation of provider eligibility and enrollment business processes. Alignment with the MITA framework and adoption of the SSC are key requirements for implementation. Communication and coordination between MLTC, its clients, and other stakeholders will be significantly enhanced. For example, provider applications for Medicaid participation will be fully electronic.

5.5.2. Recommendations

Business Results are the outcome of the coordinated efforts and activities of the entire Medicaid enterprise. Department leadership should identify and declare specific measurable business

[5] SS-A Appendix A – Seven Standards and Conditions 3.0, CMS, February 2012, Version 3.0.

results as part of the SMA's strategic plan and its mission, goals, and objectives. Intended results should be stated for each of the ten business areas.

5.5.2.1. Business Architecture

- *SOPs project:* Proceed with initiation of the SOPs project recommended in the MITA Roadmap. Business Results are affected by the level of quality, accuracy, uniformity, standardization, accessibility, and comprehensiveness of well-maintained and documented procedures. Department leadership should develop an enterprise-wide set of standards and practices for sustainable management of the Agency's processes.
- *Performance measurement project:* Proceed with initiation of the performance measures project recommended in the MITA Roadmap. Department leadership should develop an enterprise-wide strategy for unifying and standardizing performance measurement tools and activities. It should delegate business area and business process-specific follow-through actions to appropriate managers and process owners. Measurable business results at the business process level should be developed, reviewed, and approved. These should include, at a minimum, all processes which require specific response times or turnaround times per regulation, legislation, or policy.

5.5.2.2. Information Architecture

- *Service level measures*: As part of each business project the SMA should establish key performance indicators, automate the reporting of these measures, and establish alerts that prompt business owners to address outliers.

5.5.2.3. Technical Architecture

- *Use of Business activity monitoring (BAM):* The primary intent of BAM is to provide a real-time summary of business activities to operations managers and Agency leadership. BAM should enable the SMA to make better informed business decisions and more quickly address problem areas. A common feature provided by BAM solutions is the presentation of information via dashboards with key performance indicators (KPIs); the KPIs provide good visibility into business activities and performance.

5.6. Reporting Condition

Solutions should produce transaction data, reports, and performance information that can contribute to program evaluation, continuous improvement in business operations, and transparency and accountability. Systems should be able to produce accurate data that can be used for program oversight and improvement. These reports should be automatically generated

through open interfaces to designated federal repositories or data hubs, with appropriate audit trails. [6]

5.6.1. Activities Contributing to the Standard

The following report areas contribute to the Reporting condition:

- Member management
- Provider management
- Eligibility and enrollment
- Financial reporting
- Quality reporting
- Operations reporting
- Performance reporting
- Budget reporting
- Contractor and business relationship management

Currently, the SMA is implementing several initiatives which will substantially contribute to the Reporting condition. These include:

- AS-ECS – The purpose of this project is to comply with the first set of mandated operating rules that apply to the eligibility (270/271) and claims status (277/278) HIPAA transactions. The project will be implemented in two parts, data content and connectivity. MLTC contracted with a vendor to establish the infrastructure for the connectivity and real time requirements.
- AS-EFT/ERA – The purpose of this project is to comply with the second set of mandated operating rules that apply to EFT and ERA transactions. The project will be implemented in two parts, data content and connectivity. MLTC will contract with a vendor to establish the infrastructure for the connectivity requirements.
- CMS quarterly reports – This project will ensure that quarterly CMS report deficiencies are defined and rectified and overall quality improvements are implemented.
- EES – This project will replace the eligibility and enrollment functions of the State's legacy system. Alignment with the MITA framework and adoption of the SSC are key implementation requirements. The new system's ability to configure and generate both standard and ad hoc reports will contribute to adoption of the Reporting condition.
- EHR Incentive Payment Program – The purpose of this project is to determine the best solution to receive enrollments, MU measures, and other documentation from providers;

[6] SS-A Appendix A – Seven Standards and Conditions 3.0, CMS, February 2012, Version 3.0.

allow for interfaces to create file transfers with CMS; allow for interfaces to do certain eligibility checks; allow for interfaces so payments can continue to be submitted through the Enterprise One system; enable accurate reporting to CMS; and support tracking of the MU measures.

- MMIS replacement – This project will replace the legacy MMIS, enabling uniform and standardized automation of claims processes as well as other related processes. Alignment with the MITA framework and adoption of the SSC are key requirements of this initiative. It is anticipated that configurable standard and ad hoc reports will be supported.
- PS&E – This project will result in unified and standardized automation of provider eligibility and enrollment business processes. Alignment with the MITA framework and adoption of the SSC are key implementation requirements. The new system's ability to configure and generate both standard and ad hoc reports will contribute to adoption of the Reporting condition.

5.6.2. Recommendations

Department leadership should develop an enterprise-wide compendium of current reports and reporting requirements. This will contribute to integration of these initiatives:

- Enterprise data management strategy
- SOPs
- Performance measures
- MMIS replacement
- EES
- Provider screening and enrollment system
- EHR Incentive Payment Program
- AS-ECS/EFT-ERA

5.6.2.1. Business Architecture

- *Report utilization*: Review the reports generated in each business area for relevance, redundancies, and reusability as part of the enterprise-wide integration of reports and reporting requirements.
- *Performance measure reporting*: Develop a method for identifying, unifying, standardizing, and integrating performance measurement reports, taking into account the spectrum of stakeholders involved.

5.6.2.2. Information Architecture

- *Standardized Reporting*: Establish the governance process and structure to facilitate standardized program reporting and the methods by which reporting is communicated.

This standardization should include ensuring that information is consistently queried and that the report context is communicated.

5.6.2.3. Technical Architecture

- *Data dictionary:* Establish a data dictionary which contains information such as the meaning of a data element, the relationship between a data element and other data, and the origin and format of the data element. By establishing a complete, well-defined data dictionary, business analysts can better understand and navigate data in the Medicaid systems environment, and reduce the need for IT support.
- *Data warehouse strategy and platform:* Use the data warehouse platform to support standardized reporting and data analysis. It would provide a central repository of integrated data from one or more systems, and contain both current and historical data. Through the use of standard reporting and business intelligence tools, business analysts can use the data warehouse to support a wide range of strategic and operational business decisions.

5.7. 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, outreach, and enrollment assistance services. [7]

5.7.1. Activities Contributing to the Standard

Currently, the SMA eligibility and enrollment function includes integration with the Federally Facilitated Marketplace in support of ACA compliance. Interoperability is also supported by:

- HIE – This will contribute to determining health care trends and developing data analytics using shared medical information.
- MMIS replacement – This will contribute to the SMA's technical and business ability to share data and interact internally and with other entities in a cost effective manner.

5.7.2. Recommendations

Department leadership should develop standards and practices to support interoperability both internally and in standardizing interactions with other entities. This will contribute to alignment with the MITA framework, especially in terms of cost effectiveness, efficiency, data access and accuracy, and stakeholder satisfaction.

[7] SS-A Appendix A – Seven Standards and Conditions 3.0, CMS, February 2012, Version 3.0.

5.7.2.1. Business Architecture

- *MMIS replacement*: Identify opportunities to develop requirements, measures, standards, and practices for interoperability.

5.7.2.2. Information Architecture

- *Enterprise data management strategy*: Identify and catalog current examples and instances of interoperability in MLTC projects, standards, and practices. Develop a method for increasing interoperability within the SMA and with other entities.
- *Data management strategy:* As part of the data management and governance project, document the standard policies for the exchange of data between systems. The policies should require the use of industry standard data exchange formats for future interface development. The use of standards provides support for interoperability.
- *Data governance:* The data management and governance project should also establish a governance process, such as an implementation review process, to verify that system development efforts are in compliance with established policies.

5.7.2.3. Technical Architecture

- *Interface automation:* Real-time access to system information that supports Medicaid could improve interoperability as the SMA moves to more interactive business and systems processing. In addition, the ability to access the data directly from the source system would reduce data replication that can cause inconsistencies between interfacing systems.
- *Business process management (BPM):* Traditionally, workflow management has focused on directing documents and tasks for further actions to users in a business process. This is typically accomplished through the use of work queues, alerts, and triggers. BPM takes a more structured approach, in which workflow automation is only part of the solution. BPM delivers greater visibility and control as it integrates the workflow with various applications, technologies, and human-related tasks across vertical and horizontal boundaries. BPM solutions leverage a number of tools that can help the business operate more smoothly, such as process modeling, workflow automation, process management and analysis, and the use of enterprise application integration software.

6. MITA Gap Analysis

This section presents the gaps that must be considered and addressed for each MITA business area and their respective business processes as Nebraska transitions from As-Is to To-Be MITA capabilities. While MITA business area To-Be summaries were provided in Section 3, this gap analysis was performed at the business process level for each business area. It provides a description of major gaps that were found for each business process and the project(s) that will address those gaps. If the recommended projects are implemented, there will be a measurable improvement in each business process' MITA maturity level. The gap analysis includes an evaluation of each business process' strengths, challenges, and opportunities for improvement to enable the SMA to close any maturity gaps.

The gap analysis determined that there are common gaps for one or more business processes within every business area and across business areas. These common gaps are listed in the following table. Details of each project that will address a gap can be found in Section 7, Nebraska MITA 3.0 Roadmap.

Gap Reference Number	Gap Description	Project(s) Addressing Gap
A	Outdated or limited documentation of business processes	SOPs
B	Limited and non-standardized data governance	Enterprise data management strategy
C	Limited performance measures, including stakeholder satisfaction, for most business processes	Performance measures
D	Lack of uniform standardized and automated process coordination capability	Workflow management improvement
E	Legacy MMIS impedes Medicaid transformation and process improvements.	MMIS replacement

Table 8 - Common Gaps

There are also business area-specific gaps where one or more business process within that business area are affected. These specific business area gaps are documented under each respective business area in the following pages.

6.1. Business Relationship Management

The BR business area relies on manual activities, disparate data sources, and non-standardized procedures for process fulfillment. This business area will benefit from application of the common MITA Roadmap projects, especially SOPs, workflow management, enterprise data management strategy, and performance measures.

The following table depicts gaps that are not common across all MITA business areas, but are specific to one or more of the business processes within the BR area.

BR Gap Reference Number	BR Gap Description	Project(s) Addressing Gap
1	Data is stored in disparate systems. Some data stores are proprietary and do not conform to data management standards. Different types of agreements are handled and stored differently	MITA transformation

Table 9 - BR-Specific Gaps

6.1.1. Projects Addressing Maturity Gaps by Process

The following table references each business process within this business area and whether a gap exists. References to A, B, C, D, and E refer to the common gaps identified in Table 8.

Business Process	MITA Maturity Level By Process		Common Gaps					BR Gaps					
BR	As-Is	To-Be	A	B	C	D	E	1					
BR01 – Establish business relationship	1	2	X	X	X	X	X	X					
BR02 – Manage business relationship communication	1	2	X	X	X	X	X	X					
BR03 – Manage business relationship information	1	2	X	X	X	X	X	X					
BR04 – Terminate business relationship	1	2	X	X	X	X	X	X					

Table 10 - BR Business Process Gaps

6.2. Care Management

The evolution of MITA maturity levels is underway for the CM business area. The SMA is implementing the BIP and a new EES that will improve maturity levels for several processes.

These and projects related to the MMIS procurement will have a measurable improvement on maturity levels for this business area.

The following table depicts gaps that are not common across all MITA business areas but are specific to one or more of the business processes within the CM area.

CM Gap Reference Number	CM Gap Description	Project(s) Addressing Gap
1	No single entry point or conflict- free case management	BIP
2	Lack of sharing of common data between sister agencies (e.g., Public Health)	MITA transformation project
3	Ability to assess and define recipient service needs, coordinate care, and integrate services effectively and efficiently is lacking	MLTSS
4	No current compliance with the new T-MSIS reporting measures, including clinical information	T-MSIS

Table 11 - CM-Specific Gaps

6.2.1. Projects Addressing Maturity Gaps by Process

Table 12 references each business process within this business area and whether a gap exists.

Business Process	MITA Maturity Level By Process		Common Gaps					CM Gaps			
CM	As-Is	To-Be	A	B	C	D	E	1	2	3	4
CM01 – Establish case	1	2	X	X	X	X	X	X		X	
CM02 – Manage case information	1	2	X	X	X	X	X	X		X	
CM03 – Manage population health outreach	1	3	X	X	X	X	X			X	X
CM04 – Manage registry	1	2	X	X	X	X	X		X		X
CM05 – Perform screening assessment	1	3	X	X	X	X	X			X	X
CM06 – Manage treatment plan and outcomes	1	2	X	X	X	X	X	X		X	X
CM07 – Authorize referral	2	3	X	X	X	X	X			X	
CM08 – Authorize services	1	3	X	X	X	X	X	X		X	
CM09 – Authorize treatment plan	1	2	X	X	X	X	X	X		X	X

Table 12 - CM Business Process Gaps

6.3. Contractor Management

The CO business area involves processes that require coordination with other departments within Nebraska DHHS and with other state agencies. Management of diverse types of contracts is necessary to achieve intended process outcomes. Process improvements will measurably benefit from application of the MITA Roadmap common projects, especially SOPs, the enterprise data management strategy, workflow management, and MITA transformation (central repository for contractor/contract data).

Table 13 depicts gaps that are not common across all MITA business areas but are specific to one or more of the business processes within the CO area.

CO Gap Reference Number	CO Gap Description	Project(s) Addressing Gap
1	Limited knowledge and control of interagency procurement processes, contract requirements, and contract management results in errors, rework, and work duplication	MITA transformation

Table 13 - CO-Specific Gaps

6.3.1. Projects Addressing Maturity Gaps by Process

The following table references each business process within this business area and whether a gap is applicable.

Business Process	MITA Maturity Level By Process		Common Gaps					CO Gaps					
CO	As-Is	To-Be	A	B	C	D	E	1					
CO01 – Manage contractor information	1	2	X	X	X	X	X	X					
CO02 – Manage contractor communication	1	2	X	X	X	X	X	X					
CO03 – Perform contractor outreach	1	2	X	X	X	X	X						
CO04 – Inquire contractor information	1	2	X	X	X	X	X	X					
CO05 – Produce solicitation	1	2	X	X	X	X	X						
CO06 – Award contract	1	2	X	X	X	X	X						
CO07 – Manage contract	1	2	X	X	X	X	X	X					
CO08 – Close-out contract	1	2	X	X	X	X	X	X					
CO09 – Manage contractor grievance and appeal	1	2	X	X	X	X	X	X					

Table 14 - CO Business Process Gaps

6.4. Eligibility and Enrollment Management

The EE business area is heavily involved in Medicaid transformation with the acquisition of a new EES and a PS&E system. These projects can be leveraged to provide initial examples of the coordination of enterprise data management strategy, workflow management, SOPs, and performance measures.

The following table depicts gaps that are not common across all MITA business areas, but are specific to one or more of the business processes within the EE area.

EE Gap Reference Number	EE Gap Description	Project(s) Addressing Gap
1	Current EESs are legacy systems and difficult/costly to maintain	EES
2	Current PM functions rely on a mix of automated and manual procedures. Providers must submit paper/fax applications. Re-certification and re-credentialing are manual. Processes are prone to errors, rework, and/or duplication	PS&E system

Table 15 - EE-Specific Gaps

6.4.1. Projects Addressing Maturity Gaps by Process

Table 16 references each business process within this business area and whether a gap is applicable.

Business Process	MITA Maturity Level By Process		Common Gaps					EE Gaps					
EE	As-Is	To-Be	A	B	C	D	E	1	2				
EE01 – Determine member eligibility	2	3	X	X	X	X	X	X					
EE02 – Enroll member	1	2	X	X	X	X	X	X					
EE03 – Disenroll member	1	2	X	X	X	X	X	X					
EE04 – Inquire member eligibility	1	3	X	X	X	X	X	X					
EE05 – Determine provider eligibility	1	2	X	X	X	X	X		X				
EE06 – Enroll provider	1	3	X	X	X	X	X		X				
EE07 – Disenroll provider	1	3	X	X	X	X	X		X				
EE08 – Inquire provider information	2	2	X	X	X	X	X		X				

Table 16 - EE Business Process Gaps

6.5. Financial Management

In order for the FM business area to meets its MITA maturity goals, the SMA must focus on improving data sharing between the State's financial system and its Medicaid systems. In addition, the automation of financial processes, development of performance and stakeholder satisfaction measures, and documentation of SOPs will be required.

Implementation of the new EES and modernization of the MMIS will be key factors in supporting automation of financial processes and the documentation of business processes; all these activities will increase the MITA qualities of efficiency, accuracy/process results, timeliness, and data accuracy and access, and produce a higher MITA maturity level for the FM area.

The following table depicts gaps that are not common across all MITA business areas, but are specific to one or more of the business processes within the FM area.

FM Gap Reference Number	FM Gap Description	Project(s) Addressing Gap
1	Current process does not comply with ACA- mandated operation rules for EFT	AS-EFT/ERA
2	The quality and timeliness of quarterly financial reports concern CMS	CMS quarterly report
3	Current process does not comply with the HITECH Act	EHR incentive Payment Program
4	Medicaid costs need to be controlled in the long-term	HIE
5	Implementation of ICD-10 is not complete	ICD-10 project
6	Lack of budgeting software with predictive modeling and forecasting abilities and insufficient training for some business processes. Providers currently are unable to access MDR due to security maintenance issue between IS&T and MLTC. Lack of data exchange with Vital Statistics. Lack of understanding of best practices for management of grants. Providers are not informed of tax-related concerns. No alert notification from Enterprise One to EES. No web portal capabilities for contractors to submit invoices to MLTC contract managers. No online capability for completing HIPP cost effectiveness worksheet and submitting it online	MITA transformation project

Table 17 - FM-Specific Gaps

6.5.1. Projects Addressing Maturity Gaps by Process

The following table references each business process within this business area and whether a gap is applicable.

Business Process	MITA Maturity Level By Process		Common Gaps					FM Gaps					
FM	As-Is	To-Be	A	B	C	D	E	1	2	3	4	5	6
FM01 – Manage provider recoupment	1	2	X	X	X	X	X	X				X	
FM02 – Manage TPL recovery	1	2	X	X	X	X	X	X				X	
FM03 – Manage estate recovery	1	2	X	X	X	X	X						X
FM04 – Manage drug rebate	1	2	X	X	X	X	X	X				X	X
FM05 – Manage cost settlement	1	2	X	X	X	X	X	X				X	
FM06 – Manage accounts receivable information	2	2	X	X	X	X	X	X					
FM07 – Manage accounts receivable funds	2	2	X	X	X	X	X						
FM08 – Prepare member premium invoice	1	2	X	X	X	X	X						X
FM09 – Manage contractor payment	1	2	X	X	X	X	X	X					X
FM10 – Manage member financial participation	1	2	X	X	X	X	X						X
FM11 – Manage capitation payment	1	3	X	X	X	X	X	X				X	
FM12 – Manage incentive payment	1	3	X	X	X	X	X		X	X	X	X	
FM13 – Manage accounts payable information	2	2	X	X	X	X	X	X				X	
FM14 – Manage accounts payable disbursement	2	2	X	X	X	X	X	X				X	
FM15 – Manage 1099	2	2	X	X	X	X	X						X
FM16 – Formulate budget	1	2	X	X	X	X	X						X
FM17 – Manage budget information	1	2	X	X	X	X	X						
FM18 – Manage fund	1	2	X	X	X	X	X		X	X	X		X
FM19 – Generate financial report	1	2	X	X	X	X	X		X	X	X	X	

Table 18 - FM Business Process Gaps

6.6. Member Management

The ME business area will benefit from the deployment of the new EES, especially for timely and effective coordination and communication with clients.

The following table depicts gaps that are not common across all MITA business areas, but are specific to one or more of the business processes within the ME area.

ME Gap Reference Number	ME Gap Description	Project(s) Addressing Gap
1	Current EES and ME systems are legacy systems and difficult/costly to maintain. Processes are prone to errors, duplication, or rework.	EES

Table 19 - ME-Specific Gaps

6.6.1. Projects Addressing Maturity Gaps

Table 20 references each business process within this business area and whether a gap exists.

Business Process	MITA Maturity Level By Process		Common Gaps					ME Gaps					
ME	As-Is	To-Be	A	B	C	D	E	1					
ME01 – Manage member information (under development)	1	3	X	X	X	X	X	X					
ME02 – Manage applicant and member communication (under development)	2	3	X	X	X	X	X	X					
ME03 – Perform population and member outreach (under development)	1	2	X	X	X	X	X	X					
ME08 – Manage member grievance and appeal (under development)	1	2	X	X	X	X	X	X					

Table 20 - ME Business Process Gaps

6.7. Operations Management

Throughout the gap analysis, the MITA team identified new or existing efforts that will enable the SMA to progress to its identified maturity levels for each business process within the OM business area.

An updated MMIS is necessary to achieve a significant increase in maturity levels for OM. The SMA is currently analyzing the best strategy to modernize its MMIS. Regardless of the strategy chosen, MMIS modernization will have a measurable impact on all business areas within the

MITA framework, but none more than the OM area. Although the SMA is gradually moving towards a higher level of maturity as a result of the AS and Rates and Reimbursement projects, modernization of the MMIS is essential for the SMA to reach To-Be maturity goals.

The following table depicts gaps that are not common across all MITA business areas, but are specific to one or more of the business processes within the OM area.

OM Gap Reference Number	OM Gap Description	Project(s) Addressing Gap
1	Current process does not comply with ACA- mandated operation rules for EFT	AS-EFT/ERA
2	The ability to assess and define recipient service needs, coordinate care, and integrate services needs to be more efficient	MLTSS
3	Implementation of ICD-10 is not complete	ICD-10 project
4	Proprietary EES is not ACA compliant	EES
5	No current compliance with the new T-MSIS reporting measures, including medical services claims frequency information	T-MSIS
6	Insufficient training for some business processes. Lack of data exchange with Vital Statistics. No online capability for completing HIPP cost effectiveness worksheet and submitting it online. Rate schedules are not published with the full decimal places, which can cause misunderstandings with providers. Providers cannot submit claims online or view claim status/payment information. Data is not easily obtained from the data warehouse for quality improvement and program integrity purposes.	MITA transformation project
7	Lack of compliance with ACA HIPAA transaction standards	AS-ECS

Table 21 - OM-Specific Gaps

6.7.1. Projects Addressing Maturity Gaps by Process

Table 22 references each business process within this business area and whether a gap exists.

Business Process	MITA Maturity Level By Process		Common Gaps					OM Gaps						
OM	As-Is	To-Be	A	B	C	D	E	1	2	3	4	5	6	7
OM04 – Submit electronic attachment	1	2	X	X	X	X	X			X			X	X
OM05 – Apply mass adjustment	1	3	X	X	X	X	X	X		X		X	X	X
OM07 – Process claims	1	3	X	X	X	X	X	X		X	X	X	X	X
OM14 – Generate remittance advice	2	2	X	X	X	X	X	X		X			X	X
OM18 – Inquire payment status	2	2	X	X	X	X	X	X			X		X	X
OM20 – Calculate spend-down amount	1	3	X	X	X	X	X			X	X		X	X
OM27 – Prepare provider payment	1	2	X	X	X	X	X	X	X	X	X		X	X
OM28 – Manage data	1	2	X	X	X	X	X		X			X	X	X
OM29 – Process encounters	1	3	X	X	X	X	X	X	X	X	X	X	X	X

Table 22 - OM Business Process Gaps

6.8. Performance Management

The development of a data management and governance strategy, as well as an information and analysis strategy, is essential to improve this business area's maturity. Both these strategies will be vital in order for the SMA to move from an operational focus to one that is based on information and analytics.

The SMA needs to develop more robust utilization and compliance processes for all areas (e.g., provider, client, quality review) with a focus on contract compliance and oversight. In addition, the SMA should determine the cost benefit of acquiring a case tracking system in order to allow automation of daily tasks. Documentation of SOPs, development of performance measures, and the completion of stakeholder satisfaction surveys are also required.

The following table depicts gaps that are not common across all MITA business areas, but are specific to one or more of the business processes within the PE area.

PE Gap Reference Number	PE Gap Description	Project(s) Addressing Gap
1	Limited or unreliable eligibility and enrollment data for analytics and reporting due to out dated EES	EES
2	Limited or unreliable provider information available for analytics due to legacy PS&E system	PS&E
3	Current data warehouse does not have the capability to house new T-MSIS reporting measures	T-MSIS
4	Lack of data sharing between Medicaid and its sister agencies. Lack of training for new hires on some work processes	MITA transformation project

Table 23 - PE-Specific Gaps

6.8.1. Projects Addressing Maturity Gaps by Process

Table 24 references each business process within this business area and whether a gap exists.

Business Process	MITA Maturity Level By Process		Common Gaps					PE Gaps					
PE	As-Is	To-Be	A	B	C	D	E	1	2	3	4		
PE01 – Identify utilization anomalies	1	2	X	X	X	X	X	X	X	X	X		
PE02 – Establish compliance incident	1	2	X	X	X	X	X	X	X	X	X		
PE03 – Manage compliance incident information	1	2	X	X	X	X	X	X	X	X	X		
PE04 – Determine adverse action incident	1	2	X	X	X	X	X	X	X	X	X		
PE05 – Prepare REOMB	1	2	X	X	X	X	X	X					

Table 24 - PE Business Process Gaps

6.9. Plan Management

The SMA has a number of challenges in the PL area (as do most states). Processes are mostly manual, and documentation of these processes is often lacking. These factors cause a non-standard of application of rules and regulations to several processes, including setting rates, managing reference information, and maintaining programs. Data is not easily accessible or

standardized due to disparate systems. Often the data used to determine agency goals and objectives or develop new programs is flawed or difficult to obtain.

A focus on a unified data management and governance strategy and an information and analysis strategy will be essential to improve this business area's maturity level. Development of performance and stakeholder measures; documentation, standardization, and automation of business processes, and improvement of workflow administration is needed to achieve To-Be maturity levels.

The following table depicts gaps that are not common across all MITA business areas, but are specific to one or more of the business processes within the PL area.

PL Gap Reference Number	PL Gap Description	Project(s) Addressing Gap
1	Limited eligibility and enrollment data are available to develop measurable performance measures for EES	EES
2	Implementation of ICD-10 is not complete	ICD-10 project
3	Currently the published rate schedules do not display all four decimal places which cause providers to question payment rates. The SMA does not have a standardized process for developing or publishing agency goals and objectives. Some State Plan sections and regulations need to be updated. Lack of knowledge transfer, training, and documented processes for the various rate setting activities. Currently the State Plan is difficult to navigate because of a lack of a comprehensive index.	MITA transformation project

Table 25 - PL-Specific Gaps

6.9.1. Projects Addressing Maturity Gaps by Process

Table 26 references each business process within this business area and whether a gap exists.

Business Process	MITA Maturity Level By Process		Common Gaps					PL Gaps					
PL	As-Is	To-Be	A	B	C	D	E	1	2	3			
PL01 – Develop agency goals and objectives	1	2	X	X	X	X	X			X			
PL02 – Maintain program policy	1	2	X	X	X	X	X			X			
PL03 – Maintain State Plan	1	2	X	X	X	X	X			X			
PL04 – Manage health plan information	1	3	X	X	X	X	X		X				
PL05 – Manage performance measures	1	2	X	X	X	X	X	X		X			
PL06 – Manage health benefit information	1	3	X	X	X	X	X		X				
PL07 – Manage reference information	1	3	X	X	X	X	X		X	X			
PL08 – Manage rate setting	1	2	X	X	X	X	X			X			

Table 26 - PL Business Process Gaps

6.10. Provider Management

The PM business area will benefit from application of the common MITA Roadmap projects, especially SOPs, performance measures and the enterprise data management strategy. The new PS&E system will be leveraged to provide increased standardization of processes, reporting, and data exchange.

The following table depicts gaps that are not common across all MITA business areas, but are specific to one or more of the business processes within the PM area.

PM Gap Reference Number	PM Gap Description	Project(s) Addressing Gap
1	Current PM functions rely on a mix of automated and manual processes. Providers must submit paper/fax applications. Re-certification and re-credentialing are manual. Processes are prone to errors, rework, and/or duplication	PS&E system
2	Coordination of data with NeHII is manual. Automation would enhance coordination and standardization opportunities such as increased support of Medicaid providers' MU activities	HIE

Table 27 - PM-Specific Gaps

6.10.1. Projects Addressing Maturity Gaps by Process

Table 28 references each business process within this business area and whether a gap exists.

Business Process	MITA Maturity Level By Process		Common Gaps					PM Gaps					
	As-Is	To-Be	A	B	C	D	E	1	2				
PM01 – Manage provider information	1	2	X	X	X	X	X	X	X				
PM02 – Manage provider communication	1	2	X	X	X	X	X	X	X				
PM03 – Perform provider outreach	1	2	X	X	X	X	X	X					
PM07 – Manage provider grievance and appeal	1	2	X	X	X	X	X	X					
PM08 – Terminate provider	1	2	X	X	X	X	X	X					

Table 28 - PM Business Process Gaps

7. Nebraska MITA 3.0 Roadmap

7.1. Roadmap Background and Overview

The projects described in Nebraska's MITA 3.0 Roadmap are designed to support DHHS' strategic plan as well as the SSC. While certain federal projects, initiatives, and requirements must be addressed over the next six years, MLTC intends to leverage these projects as possible and incorporate ongoing (or planned) projects to bridge the gap between the SMA's As-Is and To-Be environments. Given any agency's resource constraints, procurement cycles, and existing contracts, new projects must be carefully planned and timed to provide optimal impact with minimal disruption.

Nebraska's MITA 3.0 Roadmap provides a basis for detailed project descriptions required for federal funding requests. DHHS will submit APDs where appropriate to request enhanced funding from CMS for projects included in MITA 3.0. As with all other DHHS initiatives, the projects will be prioritized by executive management.

Each project in the MITA 3.0 Roadmap supports improvement in maturity of at least one MITA business process, but usually more than one. The State will seek opportunities to mature in and support all SSC in a manner that recognizes the constraints of limited resources but also recognizes the value and benefits outlined in the SSC.

As described in the SS-A Companion Guide, CMS expects all states to prepare/submit a MITA Roadmap, and make measurable progress in implementing it. As required by CMS, DHHS' Roadmap:

- Addresses goals and objectives, as well as key activities and milestones, covering a five-year outlook for proposed system solutions, as part of the APD process.
- Will be updated on an annual basis.
- Demonstrates how the SMA will improve in MITA maturity over the next five years and its anticipated timing for full MITA maturity.
- Includes a sequencing plan that considers cost, benefit, schedule, and risk.
- Ensures that its BA conforms to the COO and BPM distributed by CMS for specific functions, or identifies divergences.

Nebraska's MITA 3.0 Roadmap include the following three sections:

MITA Roadmap Section	Section Content
Statement of Goals and Objectives	This section begins with a statement of purpose, including MLTC's vision for its roadmap, needs, objectives, and anticipated benefits. It also ensures the State's compliance with regulations. It finally identifies and describes the State's workgroups or collaborative efforts.
Project Management Plan	The Project Management Plan summarizes how the SMA will assess its As-Is operations and To-Be enterprise environment. It briefly describes the planning process and discusses how the SMA will conduct the planning activities, as well as the schedules and milestones for completion of key events.
Proposed Project Budget	The Budget presents 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.

Table 29 - NE MITA 3.0 Roadmap Sections

Figure 19 - Nebraska MITA 3.0 Roadmap 2014-2020Figure 19 provides an illustration of the current and planned projects included in the MITA 3.0 Roadmap. The Gantt chart is Nebraska's planned timeline – the Roadmap may change based on future MITA framework updates, State and/or federal fiscal impacts, other constraints such as availability of MITA national standards for data exchange and messaging (when they are developed and released by CMS), or State resource changes.

ID	Task Name	Start	Finish
1	Administrative Simplification (AS-Eligibility Claim Status)	09/03/2012	01/30/2015
2	Administrative Simplification (AS-Electronic Funds Transfer, Electronic Remittance Advice)	04/01/2013	11/28/2014
3	Balanced Incentive Program	05/01/2014	09/30/2015
4	CMS Quarterly Reports	12/02/2013	***12/31/2015***
5	Eligibility and Enrollment System	07/01/2014	04/29/2016
	Electronic Health Records Incentive Payment Program	09/03/2012	05/05/2022
7	Health Information Exchange	07/01/2013	***12/28/2018***
8	ICD-10	09/03/2012	06/30/2016
9	Managed Long-Term Serivces and Supports	07/01/2014	***12/30/2016***
10	MMIS Replacement	07/01/2014	***07/01/2014***
11	Provider Screening and Enrollment	09/03/2012	06/30/2015
12	Transformed-Medicaid Statistical Information System	01/01/2013	03/31/2015
13	MITA Transformation	***01/01/2015***	***12/31/2020***
14	Enterprise Data Management Strategy	***01/01/2015***	***01/01/2015***
15	Enterprise Business Intelligence and Analytics Strategy	**01/01/2015**	**01/01/2015**
16	Enterprise Workflow Management Strategy	**01/01/2016**	**01/01/2016**
17	Performance Measures - Planning and Implementation	**07/01/2015**	***07/01/2015***
18	Standard Operating Procedures - Development and Implementation	**01/01/2015**	***01/01/2015***
19	**RFP-Related Initiatives**	**07/01/2014**	**07/31/2018**
20	EES Track RFP Start Date	07/01/2014	07/01/2014
21	MLTSS Contract Award	12/31/2014	12/31/2014
22	Physical Contract Base	06/30/2015	06/30/2015
23	MMIS RFP Release	11/30/2015	11/30/2015
24	Actuarial (PH/BH) Base	03/31/2016	03/31/2016
25	DSH/UPL Base Term	06/30/2016	06/30/2016
26	Actuarial (LTSS) Base	08/31/2016	08/31/2016
27	Behavioral Contract Base	08/31/2016	08/31/2016
28	Enroll Broker Base	09/30/2016	09/30/2016
29	EQRO Base	09/30/2016	09/30/2016
30	Telligen UM Base Term	12/30/2016	12/30/2016
31	DUR Base Term	12/30/2016	12/30/2016
32	POS Base Term	12/30/2016	12/30/2016
33	DSS Base Term	07/31/2018	07/31/2018

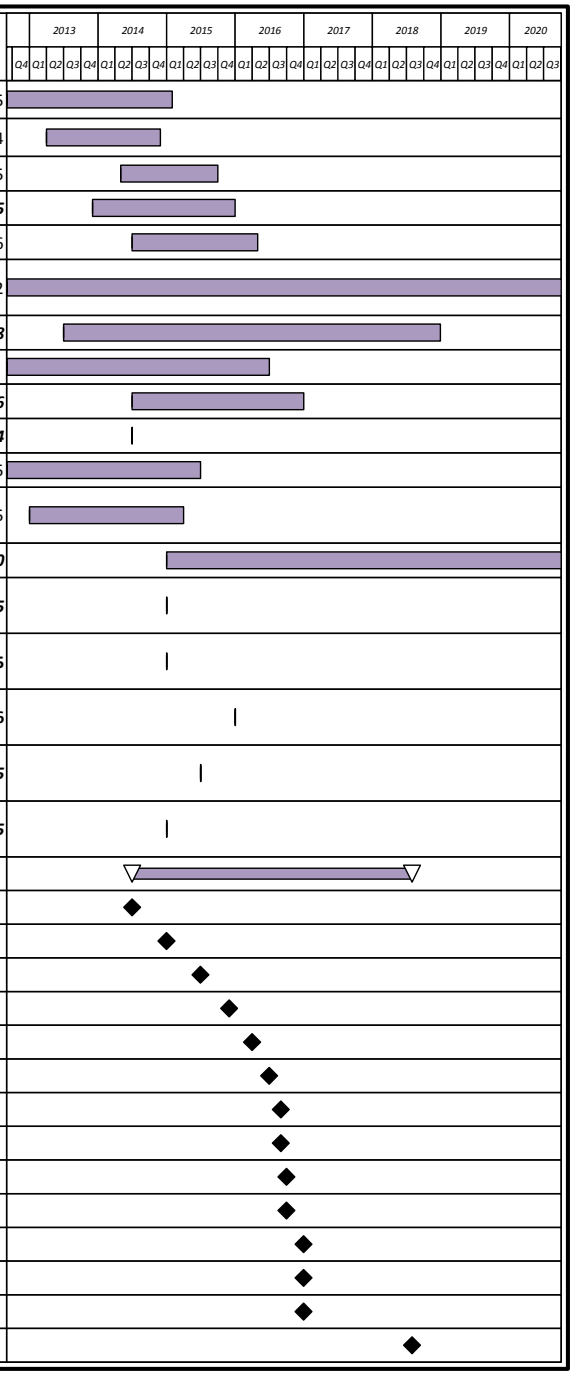


Figure 19 - Nebraska MITA 3.0 Roadmap 2014-2020

NOTE: Bolded dates indicate estimated or TBD dates.

Over the next six years, DHHS plans to continue to refine, align, and update the Roadmap to improve strategic systems planning for MITA and the SSC.

7.2. MITA 3.0 Roadmap Project Descriptions

Nebraska's MITA 3.0 Roadmap consists of the projects listed in this section. Each project described herein specifies the proposed duration, project budget, project goals and management plan, and affected MITA business processes.

7.2.1. Administrative Simplification (AS-ECS)

Duration: July 2012 – November 2014

Proposed Project Budget: Less than $5 million

Project Goals and Management Plan: HIPAA transaction standards significantly decrease the administrative burden on covered entities by creating greater uniformity in data exchange. However, gaps exist in the implementation of the standards. The ACA required the adoption of a single set of operating rules for each standard health care transaction. Operating rules define the rights and responsibilities of the parties, security requirements, transmission formats, response times, liabilities, exception processing, error resolution, etc.

The purpose of this project is to comply with the first set of mandated operating rules that apply to the eligibility (270/271) and claims status (277/278) HIPAA transactions. The project will be implemented in two parts, data content and connectivity. The SMA contracted with a vendor to establish the infrastructure for the connectivity and real time requirements.

Project goals include:

- Compliance with operating rules mandated by CMS in interim final rule CMS-0032-IFC
    - Phase I CORE 152: Eligibility and Benefit Real Time Companion Guide (updated for version 5010 for this and all subsequent bullets)
        - Goal: Standardize template/common structure of companion guides for more efficient reference
        - Requirements: Uses standard template/structure for companion guides
    - Phase I CORE 153: Eligibility and Benefits Connectivity Rule
        - Goal: Provide a ''safe harbor'' that application vendors, providers, and health plans can be assured will be supported by any trading partner, including providers, to facilitate connectivity standardization and interoperability across the exchange of health information
        - Requirements: Supports data exchange over the public Internet (HTTP/S)
    - Phase I CORE 154: Eligibility and Benefits 270/271 Data Content Rule

    - Goal: Enable more robust and consistent exchange of eligibility information
    - Requirements: Specifies what is to be included in the 271 eligibility for a health plan response to a 270 eligibility for a health plan inquiry
- Phase I CORE 155: Eligibility and Benefits Batch Response Time Rule and Phase I CORE 156: Eligibility and Benefits Real Time Response Time Rule
    - Goals: Streamline and improve flow of transactions
    - Requirements: Ensures response time is 20 seconds or less for real time, next day for batch
- Phase I CORE 157: Eligibility and Benefits System Availability Rule
    - Goal: Streamline and improve flow of transactions
    - Requirements: Ensures systems availability 86% per calendar week, and regular downtime must be published
- Phase II CORE 250: Claim Status Rule
    - Goal: Promote increased availability and usage of the health care claim status transaction through rules for real-time and batch response times, system availability, and connectivity
    - Requirements: Applies real-time and batch response times, system availability, and connectivity rules for health care claim status transactions, which were derived from the eligibility Phase I infrastructure rules
- Phase II CORE 258: Eligibility and Benefits 270/271 Normalizing Patient Last Name Rule
    - Goal: Improve patient matching
    - Requirements: Normalizes the submitted and stored last name (e.g., remove special characters, suffixes/prefixes) before trying to match
- Phase II CORE 259: Eligibility and Benefits 270/271 AAA Error Code Reporting Rule
    - Goal: Provide better information on why a match did not occur in an eligibility for a health plan request
    - Requirements: Returns specified AAA codes for each error condition
- Phase II CORE 260: Eligibility & Benefits Data Content (270/271) Rule
    - Goal: Provide additional financial responsibility/patient liability information in response to an inquiry and support more high volume service type codes
    - Requirements: Includes remaining deductible amount (plus static copayment and coinsurance information) in response to an eligibility for a health plan inquiry, along with 39 additional service type codes beyond the service type codes provided in Phase I
- Phase II CORE 270: Connectivity Rule

        - Goal: Provide more comprehensive connectivity specifications to further interoperability
        - Requirements: Includes requirements for two message envelope standards submitter authentication (i.e., username/password, digital certificates) and metadata.
- Avoidance of HIPAA penalties.

The following MITA business processes are affected by this project:

- CM – all processes
- EE – all processes
- OM – all processes

7.2.2. Administrative Simplification (AS-EFT/ERA)

Duration: April 2013 – November 2014

Proposed Project Budget: Less than $1 million

Project Goals and Management Plan: HIPAA transaction standards significantly decrease the administrative burden on covered entities by creating greater uniformity in data exchange. However, gaps exist in the implementation of the standards. The ACA required the adoption of a single set of operating rules for each standard health care transaction. Operating rules define the rights and responsibilities of the parties, security requirements, transmission formats, response times, liabilities, exception processing, error resolution, etc.

The purpose of this project is to comply with the second set of mandated operating rules that apply to EFT and ERA transactions. The project will be implemented in two parts, data content and connectivity. The SMA will contract with a vendor to establish the infrastructure for the connectivity requirements.

Project goals include:

- Compliance with operating rules mandated by CMS in interim final rule CMS-0028-IFC.
    - Phase III CORE 350: Health Care Claim Payment/Advice (835) Infrastructure Rule
        - Provide data exchange over the public internet (safe harbor)
        - Continue the use of paper remittance advice for a minimum time
        - Requires the use of Master Companion Guide Template (same as adopted under AS-ECS rules)
    - Phase III CORE 360: Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule (including CORE-required code combinations for CORE-defined business scenarios):

        - Requires additional information – missing/invalid/incomplete documentation
        - Requires additional information – missing/invalid/incomplete data from submitted claim
        - Standardizes notification that billed service not covered by health plan or not separately payable
    - Phase III CORE 370: EFT & ERA Reassociation (CCD+/835) Rule
        - Must transmit CCD+ reassociation data elements
        - Must transmit the EFT within three days of the ERA transmission
        - Must use Phase III CORE 380: EFT enrollment data rule
        - Must offer electronic enrollment for EFT
        - Must use master template and standard data elements for electronic and paper-based enrollment
    - Phase III CORE 382: ERA Enrollment Data Rule
        - Must offer electronic enrollment for ERA
        - Must use master template and standard data elements for electronic and paper-based enrollment
- Avoidance of HIPAA penalties.

The following MITA business processes are affected by this project:

- CM – all processes
- EE – all processes
- FM – all processes
- ME – all processes
- OM – OM05, OM07, OM28, OM29
- PE – all processes
- PM – all processes

7.2.3. Balanced Incentive Program (BIP)

Duration: May 2014 – September 2015

Proposed Project Budget: TBD

Project Goals and Management Plan: This project includes activities required to comply with Nebraska Legislative Bill 690, which created the Aging Nebraskans Task Force and required a grant application). The grant application was submitted on July 31, 2014 and approval was received from CMS on September 11, 2014.

The BIP offers a targeted increase in the Federal Medical Assistance Percentage (FMAP) to States that undertake structural reforms to increase access to non-institutional long-term services and supports (LTSS). The increased matching payments are tied to the percentage of a State's non-institutional LTSS spending. Nebraska qualifies to receive a 2% increase in FMAP, because its non-institutional LTSS expenditures for fiscal year 2009 was between 25 and 50 percent of its total (institutional and non-institutional) LTSS costs. In return for the increased FMAP, states are required to implement structural changes, including a no wrong door/single entry point system, a standardized comprehensive needs assessment, and conflict-free case management.

The following MITA business processes are affected by this project:

- CM – all processes
- EE – EE01, EE02, EE03, EE04
- ME – all processes

7.2.4. CMS Quarterly Reports

Duration: December 2013 – TBD

Proposed Project Budget: Less than $2M (estimate)

Project Goals and Management Plan: In December 2013, CMS expressed concern with the quality and timeliness of Nebraska's quarterly financial reports. To ensure that the deficiencies are addressed, a project team was formed in December 2013. Representatives from Financial Services, MLTC, IS&T, and Audit are included on the project team.

The objectives of this initiative are to:

1. Improve the process for generating the CMS quarterly reports (CMS-64, CMS-37, CMS 21B) to improve their quality and accuracy.
2. Increase MLTC's use of automation in producing the reports.

The following MITA business processes are affected by this project:

- FM – FM12, FM18, FM19

7.2.5. Eligibility and Enrollment System (EES)

Duration: July 2014 – April 2016

Proposed Project Budget: $55-69 million

Project Goals and Management Plan: The goal of this project is to replace MLTC's existing proprietary Medicaid E&E system with a commercial off-the-shelf (COTS) solution that is ACA compliant and meets CMS' SSC. To reach this goal within the project constraints, Nebraska has contracted with a vendor to implement an E&E COTS solution.

The following MITA business processes are affected by this project:

- CM – all processes
- EE – all processes
- FM – all processes
- ME – all processes
- OM – OM07, OM18, OM20, OM27, OM29
- PE – all processes
- PL – PL05

7.2.6. Electronic Health Records (EHR) Incentive Payment Program

Duration: May 2012 through 2021

Proposed Project Budget: TBD

Project Goals and Management Plan: The purpose of this project is to determine the best solution to 1) receive enrollments, MU measures, and other documentation from providers, 2) allow for interfaces to create file transfers with CMS, 3) allow for interfaces to perform certain eligibility checks, 4) allow for interfaces so payments can continue to be submitted through the Enterprise One system, 5) enable accurate reporting to CMS, and 6) support tracking of the MU measures. The goals of this project are to be compliant with CMS reporting and tracking requirements, which include program participation numbers, the number of providers who could demonstrate MU, and health outcome reporting.

This program was established by the HITECH Act, and for Medicaid, is administered by the states. A provider may receive a little over $63,000 over six years by adopting, implementing, upgrading, or demonstrating MU of a certified EHR system. Hospitals can receive a base rate of $2 million over two years, which can be increased or decreased by discharge numbers and growth rate trends. Incentive payments are 100% federally funded and administration of the program by Nebraska Medicaid is matched with 90% federal funding. Nebraska launched the EHR Incentive Program on May 7, 2012 and HITECH funds this program through 2021.

The following MITA business processes are affected by this project:

- BR – BR01

- CM – CM04
- EE – EE06
- FM – FM12, FM18, FM19
- ME – ME01, ME02
- PE – PE01, PE02, PE03, PE04, PE05
- PM – PM01, PM02, PM03, PM07

7.2.7. Health Information Exchange (HIE)

Duration: Long term, not necessarily time-limited

Proposed Project Budget: TBD

Project Goals and Management Plan: NeHII is the lead HIE in Nebraska and has the capability to serve any health care provider. Another HIE, Electronic Behavioral Health Information Network (eBHIN) focused on behavioral health care providers, but that eBHIN has ceased to exist in Nebraska. Both HIEs in the State were established through the eHealth Council. The main purpose of an HIE is to exchange laboratory, radiology, medication history, clinical documentation, public health information, and other medical data among Nebraska providers and hospitals. MLTC recently submitted a funding request to CMS on behalf of NeHII and eBHIN (the funding requested for eBHIN has since been denied). The 90% federal funding was approved for just over $2.4 million. This funding will support HIE infrastructure costs in the areas of improving reporting syndromic surveillance, electronic lab reporting and immunizations to public health as well as onboarding costs for certain Medicaid providers who can qualify for the Medicaid EHR Incentive program. This funding is in effect through federal fiscal year 2015.

An interface of the HIE with MLTC is not part of this funding request. HIE participation in the HIE is optional for providers. If MLTC was going to receive this information through an interface in the future, policies would require participation. This would allow MLTC to access all Medicaid recipient health information in order to determine trends and use in data analytics. This could potentially reduce Medicaid costs in the long-term and ensure consistent quality reporting. The HIE contains patient information for both Medicaid and non-Medicaid patients. Aggregate data could be obtained for comparisons to ensure that Medicaid patients have the same level of care/treatment as non-Medicaid patients.

The following MITA business processes are affected by this project:

- BR – BR01
- CM – CM04
- EE – EE06
- FM – FM12, FM18, FM19

- ME – ME01, ME02
- PM – PM01, PM02, PM03, PM07

7.2.8. ICD-10 Project (ICD-10)

Duration: August 2010 – June 2016

Proposed Project Budget: Currently estimated at $18.36 million

Project Goals and Management Plan: The primary objective of this project is to implement ICD-10 in compliance with federal requirements, while mitigating the operational risks for MLTC. The project is being managed collaboratively by MLTC and IS&T, and planning and analysis is being conducted by State staff and contracted resources. Key Medicaid program and technical managers, analysts, and SMEs are providing support throughout the project to ensure that all State and federal requirements and operational constraints are considered and addressed.

The implementation of this project has three overlapping phases:

- Awareness: Creating an initial assessment
- Assessment: Performing a detailed impact analysis, creating project artifacts (risks, issues, communication plans, for example), and reviewing high-priority edit, diagnosis, and procedure codes
- Remediation: This phase involves remediating all system- and business-related processes to support ICD-10 implementation

The following MITA business processes are affected by this project:

- BR – BR01, BR02, BR03
- FM – FM01, FM02, FM04, FM05, FM06, FM11, FM12, FM13, FM19
- ME – All processes
- OM – All processes
- PL – PL04, PL06, PL07
- PM – PM01, PM02, PM03, PM07

7.2.9. Integrated Managed Long Term Services and Supports (MLTSS)

Duration: July 2013 – TBD (project on hold due to Nebraska legislative bill)

Proposed Project Budget: $3.1 million

Project Goals and Management Plan: When implemented, MLTSS will deliver managed institutional care, State Plan services, and home and community-based services (HCBS) to Medicaid clients through managed care. The Nebraska MLTSS will include physical health, behavioral health, dental, and pharmacy services in a capitated model. MLTSS is intended to improve Nebraska's ability to assess and define recipient service needs, coordinate care, integrate services, and more effectively and efficiently deliver, manage, and pay for quality LTSS. Other anticipated outcomes include reducing reliance on institutional services, removing barriers to service delivery, improving cost predictability through capitation reimbursement, and strengthening the State's ability to measure and improve service quality.

The MMIS, N-FOCUS, and CONNECT systems that currently support the Nebraska LTSS program will require remediation to support the program changes. DHHS is utilizing the "Timeline for Developing a Managed Long Term Services and Supports (MLTSS) Program" developed by CMS and Truven Health Analytics (Truven), to guide the program's implementation. The major project phases include planning, implementation, and refinement; other tasks, such as stakeholdering, ongoing consultation with CMS, education and training, etc., will run throughout the project.

The following MITA business processes are affected by this project:

- CM – All processes
- FM – FM11, FM17
- OM – OM27, OM28, OM29

7.2.10. MMIS Replacement

Duration: July 2014 – TBD

Proposed Project Budget: TBD

Project Goals and Management Plan: The increased demands for timely and accurate data for program planning and improvement, the ability to react quickly to program changes and federal mandates, and the tools to provide ensure appropriate program oversight are just a few of the reasons improved MMIS technology is needed to move Nebraska's MMIS from a claims payment system to a health care management system. As this process begins, MLTC is documenting its Medicaid business processes, clarifying MTLC's mission and goals, establishing a strategic vision and business model consistent with its mission and goals, and plotting the course for obtaining them.

MLTC's current planning includes:

- Establishing the project's governance

- Conducting discovery, strategic planning, and project analysis of system alternatives, the procurement process, and other best practices
- Developing a project plan based on the alternatives selected. Once the project scope/plan is finalized, the MITA 3.0 Roadmap will be revised. It will include the prioritized activities and the supporting timeline
- Determining the financial model for each procurement or contract amendment
- Drafting the IAPD to obtain approval for enhanced federal funding
- Drafting the RFPs for a MMIS vendor(s) and independent verification and validation (IV&V) vendor
- Completing all planning tasks

Once the vendor(s) are selected, the project will move to the implementation phase. While the exact scope is subject to change based on the planning results, the BA To-Be assessment is based on the functionality and capabilities the SMA reasonably expects to be addressed in the MMIS project.

As the implementation phases are defined, the project dates will be updated.

The following MITA business processes are affected by this project:

- BR – All processes
- CM – All processes
- EE – All processes
- FM – All processes
- ME – All processes
- OM – All processes
- PE – All processes
- PL – All processes
- PM – All processes

7.2.11. Provider Screening and Enrollment (PS&E)

Duration: November 2011 – June 2015 (implementation only)

Proposed Project Budget: $1.5 million (implementation only)

Project Goals and Management Plan: Implementation of the new provider enrollment and screening requirements will ensure compliance with federal regulations that require that only qualified individuals and organizations be allowed to provide Medicaid services. In order to bring MLTC into compliance, the planned solution will accept and process provider agreements and related documents, conduct database checks, schedule site visits, collect and process

application fees, manage moratoria, and conduct revalidations. The objective is to contract with a vendor who will complete these functions for all Nebraska Medicaid providers. The RFP required that the vendor have the capability to accept and process paper documents, but provide a web portal for providers to enter all required enrollment information and attach all necessary forms.

The following MITA business processes are affected by this project:

- BR – All processes
- EE – EE05, EE06, EE07, EE08
- PE – PE01, PE02, PE03, PE04
- PM – All processes

7.2.12. Transformed-Medicaid Statistical Information System (T-MSIS)

Duration: January 2013 – March 2015

Proposed Project Budget: Less than $1.5 million

Project Goals and Management Plan: The T-MSIS project, which began in January 2013, is the transformation/expansion of MLTC's ability to obtain and provide federal reporting measures from MLTC's information systems. A new report will be submitted to CMS monthly instead of quarterly. Report data has been expanded to include eligibility statistics, health care quality measures, managed care measures, and information on medical services claims and their frequency. The data will be stored in the Truven Data Warehouse. MLTC staff can obtain and utilize the information through the Warehouse.

The following MITA business processes are affected by this project:

- CM – All processes
- OM – OM28, OM29
- PE – PE01, PE02, PE03, PE04

7.2.13. MITA Transformation Project

Duration: Years (start and finish dates will vary)

Proposed Project Budget: TBD

Project Goals and Management Plan: The MITA transformation project is focusing on completing the tasks needed to meet the To-Be goals not addressed by other projects in the MITA

3.0 Roadmap. This project will be managed through enterprise governance and addressed as budget and staffing allow. Specific areas/projects that will be covered are business process improvement, enterprise data management strategy, MITA transformation, outreach, systems enhancements, and training.

The following MITA business processes are affected by this project:

- BR – All processes
- CM – All processes
- CO – All processes
- EE – All processes
- FM – All processes
- ME – All processes
- OM – All processes
- PE – All processes
- PL – All processes
- PM – All processes

7.2.14. Enterprise Data Management Strategy

Duration: TBD

Proposed Project Budget: TBD

Project Goals and Management Plan: This project's goal is to develop a data management and governance strategy for the Medicaid Enterprise.

The project outcomes are to:

- Establish a workgroup consisting of MLTC and IS&T staff to assess the current Medicaid Enterprise data governance framework.
- Determine desired data management requirements and capabilities of the Medicaid Enterprise
- Improve SMA's understanding of data and where it is being sourced and establish guidelines for assessing impacts of future system or service procurements to the data management strategy.
- Establish a Medicaid Enterprise data governance strategic schedule with multiple phases for future implementation.
- Establish a Data Governance group, consisting of MLTC and IS&T staff, to continue to monitor and refine the approach.

The following MITA business processes are affected by this project:

- BR – All processes

- CM – All processes
- CO – All processes
- EE – All processes
- FM – All processes
- ME – All processes
- OM – All processes
- PE – All processes
- PL – All processes
- PM – All processes

7.2.15. Enterprise Business Intelligence and Analytics Strategy

Duration: TBD

Proposed Project Budget: TBD

Project Goals and Management Plan: The goal of this project is to develop a Business Intelligence and Analytics strategy for Medicaid Enterprise to support the desire to move from an operational based organization to a more information and analytical based organization.

The project outcomes are to:

- Establish a workgroup, consisting of MLTC and IS&T staff, to assess the current Medicaid Enterprise business intelligence and analytics environment.
- Determine desired Business Intelligence and Analytics requirement and capabilities of the Medicaid Enterprise, ensuring flexibility to accommodate the future needs of the SMA
- Improve data accessibility for the business consumer.
- Assess current and future analytics capabilities and structures for the enterprise.
- Begin the process of establishing a culture of analytics that is built on reproducible processes.
- Assess current and future staffing and skills requirements to support the strategy
- Establish a Medicaid Enterprise Business Intelligence and Analytics strategic schedule with multiple phases for future implementation.

The following MITA business processes are affected by this project:

- BR – All processes
- CM – All processes
- CO – All processes
- EE – All processes
- FM – All processes
- ME – All processes
- OM – All processes

- PE – All processes
- PL – All processes
- PM – All processes

7.2.16. Enterprise Workflow Management Strategy

Duration: TBD

Proposed Project Budget: TBD

Project Goals and Management Plan: The goal of this project is to develop a workflow management strategy for the Medicaid Enterprise to facilitate workflow between business functional areas and processes.

The project outcomes are to:

- Identify and prioritize business areas with the greatest need for workflow management by using the following criteria:
    - Timeliness and efficiency of the process
    - Cost and accuracy of the process
    - Quality of the process' end product
    - Stakeholder satisfaction with the process
- Determine which potential workflow management benefits will assist all business areas across the enterprise
- Determine the level of system integration needed for a potential workflow management solution
- Develop a strategic schedule with multiple phases to successfully initiate a workflow solution enterprise-wide

The following MITA business processes are affected by this project:

- BR – All processes
- CM – All processes
- CO – All processes
- EE – All processes
- FM – All processes
- ME – All processes
- OM – All processes
- PE – All processes
- PL – All processes
- PM – All processes

7.2.17. Performance Measures - Planning and Implementation

Duration: TBD

Proposed Project Budget: TBD

Project Goals and Management Plan: This project's purpose/goal is to establish defined and quantifiable performance measures include compliance with State and federal regulations and support MITA business qualities. These measures will address:

- Timeliness of the process
- Cost-effectiveness
- Accuracy of results
- Data access and accuracy
- Efficiency
- Utility or value to stakeholders

This project will enable MLTC to a) begin creating base-line measurements for this process; b) identify core reason for possible bottlenecks and errors that affect the process and resolve them, and c) track current progress and improvements as new processes are instituted in the future. This includes both intra-agency and with other entities (e.g., MCOs, contractors, providers).

Project will likely be completed in three phases:

1. Phase 1 – Define performance measures
2. Phase 2 – Develop methods to track, record, and analyze performance measures
3. Phase 3 – Implement improvements in the business processes and/or systems to support/improve/suggest additional performance measures

The following MITA business processes are affected by this project:

- BR – All processes
- CM – All processes
- CO – All processes
- EE – All processes
- FM – All processes
- ME – All processes
- OM – All processes
- PE – All processes
- PL – All processes
- PM – All processes

7.2.18. Standard Operating Procedures - Development and Implementation

Duration: TBD

Proposed Project Budget: TBD

Project Goals and Management Plan: The purpose/goal of this project is to ensure that all business areas have documented SOPs for all business processes, and that they are stored in a centralized, online, and easily accessible repository. By using a standardized format, keeping them updated, and utilizing an online repository, MLTC will move toward a full alignment with the MITA framework, and ensure that staff members can easily access and interpret process steps for their day-to-day tasks. Use of SOPs will increase timeliness, cost effectiveness, accuracy of each process, efficiency, and stakeholder satisfaction.

This project will likely be completed in three phases:

1. Phase 1 – Document SOPs
2. Phase 2 – Analyze existing procedures and determine gaps between current procedures and business requirements (examples include: rates and reimbursement initiative, LTSS internal audit)
3. Phase 3 – Determine/implement improvements or changes to address the gaps in the SOPs and continue to monitor and update the SOPs

The following MITA business processes are affected by this project:

- BR – All processes
- CM – All processes
- CO – All processes
- EE – All processes
- FM – All processes
- ME – All processes
- OM – All processes
- PE – All processes
- PL – All processes
- PM – All processes

8. Conclusion

8.1. MITA and the Nebraska Medicaid Enterprise

This SS-A was developed during a period of great transition for the SMA. The first phase of full ACA compliance was in its final stage; the organization was restructuring staff assignments to better perform eligibility determinations, enrollment, and change management activities; the agency was engaged in several projects to transform member and provider services; the project to replace the legacy MMIS had begun; and the State was preparing for a gubernatorial election in November 2014.

In this environment, agency leadership chose to see the MITA framework initiative not as another expensive, resource-intensive, CMS-driven exercise but rather as an opportunity to complete a business transformation. Steps have been taken to increase coordination/ cooperation both internally and with other agencies and entities, and to provide a consistent and coherent method for organizing and governing the myriad initiatives that are underway or being planned. Thus, the MITA framework, including the SS-A, the Roadmap, and the SSC is being viewed by MLTC as a catalyst for an ambitious Medicaid transformation through the implementation of the projects described in the previous section in the next six years.

8.2. Development of the SS-A

Because of the varying degrees of information to be leveraged from the NE MITA 2.0 SS-A to MITA 3.0, the three architectures took slightly different paths to perform this assessment. However, all three completed similar assessment steps for the As-Is and To-Be activities. For the As-Is, the activities included information gathering, SME consultations/meetings as necessary, and completion of assessments. For the To-Be, similar sequenced activities were used, but with an emphasis on including staff responsible for management of Medicaid programs, systems, and/or services in their respective areas. Concurrent with these activities, the MITA team reviewed MLTC's strategic plan and aligned and/or developed projects to support the desired To-Be state.

8.3. Result

This assessment resulted in a MITA Roadmap that was developed with substantial stakeholder input, supports increased levels of maturity across Nebraska's Medicaid environment, and supports MLTC's strategic plan. In a series of sessions that were held with SMEs, Administrators and other stakeholders, the desired To-Be state was developed and appropriate projects were initiated to ensure the transformation.

Projects already underway at the time this SS-A was begun include an MMIS replacement for the current legacy system, an EES that will replace legacy system functionality, and a PS&E system

that will substantially automate provider-related business processes and functions. The SMA is applying the MITA framework to the implementation of these projects. Additionally MLTC has expanded its commitment to monitoring and increasing the maturity of all ten business areas by initiating four new enterprise-wide projects: enterprise data management strategy, SOPs, enterprise workflow management strategy, and standardized performance measures. All of these projects were described in the previous section of this document.

In order to ensure monitoring and tracking of Medicaid transformation efforts, the SMA has drafted a SS-A maintenance plan that will be integrated with the SMA change request management and governance.

8.4. Conclusion

While IS&T and various entities have been doing their best to enable the SMA to fulfill its mission in a very rapidly changing environment, too many business processes rely on manual procedures which are not up-to-date or accurate. Improvements in business capability are difficult to plan, prioritize, and execute in the absence of uniform, standardized performance measures. Automation does play a major role in eligibility, enrollment, and claims processes, but the State's legacy systems have difficulty providing stable platforms to support changes in legislation, regulations, client demographics, data sharing, and business or technical innovations.

As evident in the list of Roadmap projects, the SMA is designing and building a model public health care organization with business processes and technology platforms that are stable in function yet dynamic in adaptability and flexibility. In addition, it is clear that Medicaid transformation requires that the SMA must exercise leadership in the coordination of a host of entities including but not limited to IS&T, other DHHS Divisions and state agencies (e.g., Financial Services, Legal, Support Services, and Public Health). The result will be a Medicaid enterprise with a measurably greater and more effective focus on clients' health outcomes.

Continued success will rely on the SMA to incorporate and integrate the MITA framework into daily governance and operations. This SS-A is intended to be a guiding document and a stepping stone for MLTC to achieve greater MITA maturity.

9. Appendix A – MITA Business Area Process Summaries

Description for all Business Areas and associated Business Processes:

MITA Business Process	Definition
BUSINESS RELATIONSHIP MANAGEMENT (BR)	
Standards Management	
BR01 Establish Business Relationship	The Establish Business Relationship business process encompasses activities undertaken by the State Medicaid Agency (SMA) to enter into business partner relationships. Agreements are between state agency and its partners, including collaboration amongst intrastate agencies, the interstate and federal agencies. It contains functionality for interoperability, establishment of inter-agency service agreements, identification of the types of information exchanged, and security and privacy requirements. These include Trading Partner Agreements (TPA), Service Level Agreements (SLA), and Memoranda of Understanding (MOU) with other agencies; Electronic Data Interchange (EDI) agreements with providers, Managed Care Organizations (MCOs), and others; and Centers for Medicare & Medicaid Services (CMS), other federal agencies, and Regional Health Information Organizations (RHIO).
BR02 Manage Business Relationship Communication	The Manage Business Relationship Communication business process receives requests for information, appointments, and assistance from business partners, such as inquiries related to a Service Level Agreement (SLA). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages. Information communicated by a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange EDI.
BR03 Manage Business Relationship Information	The Manage Business Relationship Information business process maintains the agreement between the State Medicaid Agency (SMA) and the other party such as the intrastate, interstate, and federal agencies. This includes routine modifications to required information such as authorized signers, addresses, terms of agreement, Key Performance Indicator (KPI), and data exchange standards.
BR04 Terminate Business Relationship	The Terminate Business Relationship business process cancels the agreement between the State Medicaid Agency (SMA) and the business partner such as the intrastate, interstate and federal agencies.
CARE MANAGEMENT (CM)	
Case Management	

MITA Business Process	Definition
CM01 Establish Case	The Care Management, Establish Case business process uses criteria and rules to: • Identify target members for specific programs. • Assign a care manager. • Assess the member's needs. • Select a program. • Establish a treatment plan. • Identify and confirm provider. • Prepare information for communication.
CM02 Manage Case Information	The Manage Case Information business process uses state-specific criteria and rules to ensure appropriate and cost-effective medical, medically-related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as: • Medicaid Waiver program case management • Home and Community-Based Services (HCBS) • Other agency programs • Disease management • Catastrophic cases • Early Periodic Screening, Diagnosis, and Treatment (EPSDT) • Immunizations for children and adults
CM03 Manage Population Health Outreach	The Manage Population Health Outreach business process is responsible for the implementation of strategy to improve general population health. The State Medicaid Agency (SMA) identifies target populations or individuals for selection by cultural, diagnostic, or other demographic indicators. The inputs to this business process are census, vital statistics, immigration, and other information sources. This business process outputs materials for: Campaigns to enroll new members in existing health plan or health benefit. • New health plan or health benefit offering. • Modification to existing health plan or health benefit offering. It includes production of information materials and communications to impacted members, providers, and contractors (e.g., program strategies and materials, etc.). The communication of information includes a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI).
CM04 Manage Registry	The Manage Registry business process receives a member's health outcome information, prepares updates for a specific registry (e.g., immunizations, cancer, disease) and responds to inquiries with response information. In the context of MITA, a medical registry consolidates related records from multiple sources (e.g., intrastate, interstate or federal agencies) into one comprehensive data store. This data store may or may not reside within the Medicaid

MITA Business Process	Definition
	information system.
CM05 Perform Screening and Assessment	The Perform Screening and Assessment business process is responsible for the evaluation of member's health information, facilitating evaluations and recording results. This business process assesses for certain health and behavioral health conditions (e.g., chronic illness, mental health, substance abuse), lifestyle and living conditions (e.g., employment, religious affiliation, living situation) to determine risk factors. This business process includes: • Establishes risk categories and hierarchy, severity, and level of need. • Screens for required fields. • Edits required fields. • Verifies information from external sources if available. • Establishes severity scores and diagnoses. • Associates with applicable service needs.
CM06 Manage Treatment Plan and Outcomes	The Manage Treatment Plan and Outcomes business process uses federal and state specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes member and member population outcomes. It includes activities to track and assess effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. It also includes ongoing monitoring, management, and reassessment of services and treatment plans for need, appropriateness, and effectiveness, and monitoring of special member populations (e.g., pregnant women and children, and HIV/intravenous drug users).
Authorization Determination	
CM07 Authorize Referral	The Authorize Referral business process is responsible for referrals between providers that the State Medicaid Agency (SMA) approves for payment, based on state policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. The SMA uses this business process primarily for Primary Care Case Management programs where additional approval controls deemed necessary by the state. Most States do not require this additional layer of control.

MITA Business Process	Definition
CM08 Authorize Service	The Authorize Service business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. Its primary use is in a fee-for-services setting.
CM09 Authorize Treatment Plan	The Authorize Treatment Plan business process encompasses both a prior authorization and post-approved treatment plan. The State Medicaid Agency (SMA) uses the Authorize Treatment Plans primarily in the care coordination setting where the care management team assesses the member's needs, decides on a course of treatment, and completes the treatment plan.
CONTRACTOR MANAGEMENT (CO)	
Contractor Information Management	
CO01 Manage Contractor Information	The Manage Contractor Information business process is responsible for managing all operational aspects of the Contractor (e.g., managed care, at-risk mental health or dental care, primary care physician, Recovery Audit Contractor (RAC)) data store. This business process receives a request for addition, deletion, or modification to Contractor information, validates the request, and applies the instruction.
CO04 Inquire Contractor Information	The Inquire Contractor Information business process receives requests for contract (e.g., managed care, at-risk mental health or dental care, Primary Care Physician (PCP)) verification from authorized providers, programs or business associates, performs the inquiry, and prepares the response for the Send Outbound Transaction.
Contractor Support	
CO02 Manage Contractor Communication	The Manage Contractor Communication business process receives requests for information, appointments, and assistance from contractors (e.g., managed care, at- risk mental health or dental care, primary care physician) such as inquiries related to modifications in Medicaid Program policies and procedures, introduction of new programs, modifications to existing programs, public health alerts, and contract amendments, etc. This business process includes the log, research, development, approval, and delivery of routine or ad hoc messages. The State Medicaid Agency (SMA) communications a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange.

MITA Business Process	Definition
CO03 Perform Contractor Outreach	The Perform Contractor Outreach business process is responsible for sending information such as public health alerts, new programs, and/or modifications in the Medicaid Program policies and procedures. For prospective contractors (e.g., managed care, at-risk mental health or dental care, primary care physician), States Medicaid Agency (SMA) develops contractor outreach information for prospective contractors identified by analyzing Medicaid business needs. For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives.
CO09 Manage Contractor Grievance and Appeal	The Manage Contractor Grievance and Appeal business process handles contractor (e.g., managed care, at-risk mental health or dental care, primary care physician) appeals* of adverse decisions or communications of a grievance. The Manage Contractor Communication business process initiates a grievance or appeal. The State Medicaid Agency (SMA) logs and tracks the grievance or appeal; it triages to appropriate reviewers; it researches it; it may request additional information; it schedules and conducts a hearing in accordance with legal requirements; and it makes a ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the contractor's information. Agency formally notifies contractor of the decision.
Contract Management	
CO05 Produce Solicitation	The Produce Solicitation business process gathers requirements, develops a solicitation (e.g., Request for Information (RFI), Request for Quotation (RFQ), or Request for Proposals (RFP)), receives approvals for the solicitation, and releases for response.
CO06 Award Contract	The Award Contract business process utilizes requirements, advanced planning documents, requests for information, request for proposal, and sole source documents to request and receive proposals, verify proposal content against Request for Proposal (RFP) or sole source requirements, apply evaluation criteria, designate contractor/vendor, post award information, entertain protests, resolve protests, negotiate contracts, and notify parties. In some States, this business process makes a recommendation of award instead of the actual award itself.
CO07 Manage Contract	The Manage Contract business process receives the contract award information, implements contract-monitoring procedures, updates contract if needed, and continues to monitor the terms of the contract throughout its duration.

MITA Business Process	Definition
CO08 Close Out Contract	The Close Out Contract business process begins with an expired contract or an order to terminate a contract. The business process ensures the obligations of the current contract are complete and the turnover to the new contractor proceeds according to contractual obligations
ELIGIBILITY AND ENROLLMENT MANAGEMENT (EE)	
Member Enrollment	
EE01 Determine Member Eligibility	The Determine Member Eligibility business process is responsible for the operational aspects of determining if an applicant is eligible for Medicaid or potentially eligible for other insurance affordability programs (e.g., Advance Premium Tax Credits through the Health Insurance Marketplace, Children's Health Insurance Program [CHIP], and/or Basic Health Program [BHP]).
EE02 Enroll Member	The Enroll Member business process receives eligibility information from the Determine Member Eligibility business process, the Marketplace, or any insurance affordability program (e.g., Children's Health Insurance Program [CHIP] or Basic Health Program [BHP]). It determines additional qualifications for enrollment in health benefits for which the member is eligible, and produces notifications for coordination of communications to the member, provider, and to the insurance affordability programs.
EE03 Disenroll Member	The Disenroll Member business process is responsible for the termination of a member's enrollment in a health plan or health benefit.
EE04 Inquire Member Eligibility	The Inquire Member Eligibility business process receives requests for eligibility verification from Health Insurance Marketplace (HIX), authorized providers, programs or business associates; performs the inquiry; and prepares the Eligibility, Coverage or Benefit Information response. The response information includes but is not limited to benefit status, explanation of benefits, coverage, effective dates, and amount for co-insurance, co-pays, deductibles, exclusions and limitations. The information may include details about the Medicaid health plans, health benefits, and the provider(s) from which the member may receive covered services.
Provider Enrollment	

MITA Business Process	Definition
EE05 Determine Provider Eligibility	The Determine Provider Eligibility business process collects enrollment application from Health Care Provider, or collects re-enrollment or revalidation information from existing Provider. The business process verifies syntax and semantic of information, checks status tracking (e.g., initial, modification, duplicate, cancelation), requests additional information when necessary, determines screening level (i.e., limited, moderate or high), verifies applicant information with external entities, collects application fees, and notifies Health Care Provider or Provider of enrollment eligibility determination (e.g., accepted, denied, or suspended). Determine Provider Eligibility business process sends enrollment determination alert signals to subscribing business processes Enroll Provider and Manage Provider Communication. Determine Provider Eligibility sends alert signal to Manage Accounts Receivable Funds business process to collect application fee.
EE06 Enroll Provider	The Enroll Provider business process is responsible for enrolling providers into Medicaid. •
EE07 Disenroll Provider	The Disenroll Provider business process is responsible for managing disenrollment in the Medicaid Program. This business process covers the activity of disenrollment including the tracking of disenrollment requests and validation that the disenrollment meets state's rules. Medicaid sends notifications to affected parties (e.g., provider, contractor, business partners) as well as alerts to other business processes to discontinue business activities.
EE08 Inquire Provider Information	The Inquire Provider Information business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry, and prepares the response information for the Send Outbound Transaction.
MEMBER MANAGEMENT (ME)	
	All of these processes are under development, CMS has not provided definitions.
ME01 Manage Member Information (Under Development)	All of these processes are under development, CMS has not provided definitions
ME02 Manage Applicant and Member Communication (Under Development)	All of these processes are under development, CMS has not provided definitions

MITA Business Process	Definition
ME08 Manage Member Grievance and Appeal (Under Development)	All of these processes are under development, CMS has not provided definitions
ME03 Perform Population and Member Outreach (Under Development)	All of these processes are under development, CMS has not provided definitions
FINANCIAL MANAGEMENT (FM)	
Accounts Receivable Management	
FM01 Manage Provider Recoupment	The Manage Provider Recoupment business process manages the determination and recovery of overpayments to providers. The State Medicaid Agency (SMA) initiates provider recoupment upon the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where provider owes monies to the SMA due to fraud or abuse.
FM02 Manage TPL Recovery	The Manage TPL Recovery business process begins by receiving Third-Party Liability (TPL) information from various sources such as external and internal information matches, tips, referrals, attorneys, compliance management incident, Medicaid Fraud Control Unit (MFCU), providers, and insurance companies. Identifies TPL carrier, locate recoverable claims, create COB file, creates post-pay recovery file, and notify other payer or provider via Manage Provider Communication process.
FM03 Manage Estate Recovery	Manage Estate Recovery is a business process that requires States to recover certain Medicaid benefits correctly paid on behalf of an individual, by filing liens against a deceased member's or deceased spouse's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), or other medical institution.
FM04 Manage Drug Rebate	The Manage Drug Rebate business process describes the process of managing drug rebate that the State Medicaid Agency (SMA) collects from manufacturers.
FM05 Manage Cost Settlement	The Manage Cost Settlement business process begins with the submission of the provider's annual Medicare Cost Report to Medicaid. Staff makes inquires for paid, denied, and adjusted claims information in the Claims data store.

MITA Business Process	Definition
FM06 Manage Accounts Receivable Information	The Manage Accounts Receivable Information business process is responsible for all operational aspects of collecting money owed to the State Medicaid Agency (SMA). Activities in this business process comply with CFR 45, Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP). Activities included in this business process can be as follows: • Periodic reconciliations between the State Medicaid enterprise and the state accounting system. • Assign account coding to transactions processed in State Medicaid enterprise. • Process accounts receivable invoicing (estate recovery, co-pay, drug rebate, recoupment, Third-Party Liability (TPL) recovery, and member premiums). • Manage cash receipting process. • Manage payment-offset process to collect receivables. • Respond to inquiries concerning accounts receivable.
FM07 Manage Accounts Receivable Funds	The Manage Accounts Receivable Funds business process is responsible for all operations aspects of the collection of payment owed to the State Medicaid Agency (SMA). Activities in this business process comply with Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP).
FM08 Prepare Member Premium Invoice	States may implement member cost sharing through the collection of premiums for medical coverage provided under Medicaid and Children's Health Insurance Program (CHIP). The State Medicaid Agency (SMA) formulates the premium amounts on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment.
Accounts Payable Management	
FM09 Manage Contractor Payment	The Manage Contractor Payment business process includes the activities necessary to reimburse contractors for services rendered based on a contract executed between the State Medicaid Agency (SMA) and the contractor. When a contractor renders services on behalf of a Medicaid member, the contractor invoices Medicaid according to the specifics defined in the contract. Agency staff responsible for Contract Administration process invoices according to the SMA policy including validation of the invoice content to reimbursement details defined in the contract.

MITA Business Process	Definition
FM10 Manage Member Financial Participation	The Manage Member Financial Participation business process is responsible for all operations aspects of preparing member premium payments. This includes premiums for Medicare, also known as Medicare Buy-in, and other health insurance. The business process begins with the alert to determine if the State Medicaid Agency (SMA) should pay a member's premium.
FM11 Manage Capitation Payment	The Manage Capitation Payment business process includes the activities to prepare Primary Care Case Management (PCCM) or Managed Care Organization (MCO) capitation payments. Some States offer members the option of enrolling in a PCCM product that requires the selection of a Primary Care Physician (PCP). The PCP receives a Per-Member-Per-Month (PMPM) capitation payment amount for all members that the State Medicaid Agency (SMA) assigns. The provider payment schedule defines the PCCM capitation rates typically actuary based on an age and gender rating or flat rate. Provider may opt in or out of PCCM plan and does not have to belong to the MCO. A prevailing alternative to the SMA integrated managed care model is to delegate specific member populations to MCOs and pay the MCO a PMPM capitation amount for all assigned members
FM12 Manage Incentive Payment	The Manage Incentive Payment business process accommodates administration of various incentive compensations to payers, providers, and members. Federal or state policy defines the programs, which are typically short duration and limited in scope. The policy defines specific periods, qualification criteria, and certification or verification requirements. The Manage Incentive Payment business process follows the Manage Program Policy business process that manages program administrative rules, whether federal or state, and concludes with paying the payer, provider, or member.
FM13 Manage Accounts Payable Information	The Manage Accounts Payable Information business process is responsible for all operational aspects of money the State Medicaid Agency (SMA) pays. Activities in this business process comply with Cash Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP). •
FM14 Manage Accounts Payable Disbursement	The Manage Accounts Payable Disbursement business process that is responsible for managing the generation of electronic and paper-based reimbursement instruments.
FM15 Manage 1099	The Manage 1099 business process describes how the State Medicaid Agency (SMA) handles IRS 1099 forms including preparation, maintenance, and corrections. Any payment or adjustment in payment

MITA Business Process	Definition
	made to a single Social Security Number (SSN) or federal Tax ID Number (TIN) impacts the business process.
Fiscal Management	
FM16 Formulate Budget	Formulate Budget business process includes the following activities: • Examines the current budget revenue stream and trends, and expenditures. • Assesses external factors affecting the program. • Assesses agency initiatives and plans. • Models different budget scenarios. • Periodically produces a new budget
FM17 Manage Budget Information	The Manage Budget Information business process is responsible for auditing all planned expenses and revenues of the State Medicaid Agency (SMA). Activities in this business process comply with Cash Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP).
FM18 Manage Fund	The Manage Fund business process oversees Medicaid funds, ensures accuracy in their allocation and the reporting of funding sources. Funding for Medicaid services may come from a variety of sources, and often, state funds span across state agency administrations, e.g., Mental Health, Aging, Substance Abuse, physical health, as well as state counties and local jurisdictions. The Manage Fund business process monitors funds through ongoing tracking and reporting of expenditures and corrects any improperly accounted expenditure. It also deals with projected and actual over and under fund allocations.
FM19 Generate Financial Report	It is essential for the State Medicaid Agency (SMA) to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the established benefits and programs are meeting the needs of the member population and are performing according to the intent of the legislative laws or federal reporting requirements.
OPERATIONS MANAGEMENT (OM)	
Payment and Reporting	

MITA Business Process	Definition
OM14 Generate Remittance Advice	The Generate Remittance Advice business process describes the activity of preparing remittance advice/encounter Electronic Data Interchange (EDI) transactions that providers use to reconcile their accounts receivables. This business process begins with receipt of information resulting from the Process Claim business process, performing required manipulation according to business rules and formatting the results into the required output information that process sends to Send Outbound Transaction.
OM18 Inquire Payment Status	The Inquire Payment Status business process begins with receiving an Accredited Standards Committee (ASC) X12 276 Health Care Claim Status Request transaction or a request for information received through other means such as email, paper, telephone, facsimile, web, or Automated Voice Response (AVR). The business process handles the request for the status of a specified claim(s), retrieves information from the claims payment history, and generates the response information. In addition, the business process formats the information into the ASC X12 277 Health Care Information Status Notification transaction, or other mechanism for responding, via the media used to communicate the inquiry, and sends claim status response via the Send Outbound Transaction.
OM27 Prepare Provider Payment	The Prepare Provider Payment business process is responsible for the preparation of the payment report information. Reports sent via email, mail, or Electronic Data Interchange (EDI) to providers and used to reconcile their accounts receivable.
OM28 Manage Data	The Manage Data business process is responsible for the preparation of the data sets and delivery to federal agencies (e.g., Centers for Medicare & Medicaid Services (CMS), Social Security Administration (SSA).) Information exchange may include extraction of Medicaid and CHIP Business Information and Solutions (MACBIS) information needs (i.e., fee-for-services, managed care, eligibility and provider information). Process includes activity to extract the information, transform to the required format, encrypt for security, and load the electronic file to the target destination. The uses for the information include: • Research and evaluation of health care activities. • Staff can forecast the utilization and expenditures for a program. • Staff can analyze policy alternatives. • State and federal agencies can respond to congressional inquiries. • Matches to other health related databases.
Claims Adjudication	

MITA Business Process	Definition
OM07 Process Claim	The Process Claim business process receives original or adjusted claim information (e.g., institutional, professional, dental, pharmacy, and waiver) via web or Electronic Data Interchange (EDI) transaction, and assigns an internal control number, performs edit and audits, pricing functions to determine submission status.
OM08 Process Encounters	The Process Encounter business process receives original or adjusted encounter (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction, determines its submission status, and based on that performs encounter edit and audits, and pricing functions.
OM20 Calculate Spend-Down Amount	The Calculate Spend-Down Amount business process is responsible for tracking spend-down amounts and determining if a member meets its responsibility through the submission of medical claims. The Process Claim business process automatically accounts for the spend-down amount during adjudication. Once the member has met the spend-down obligation, a modification of eligibility status allows Medicaid payments to begin and/or resume. This typically occurs in situations where a member has a chronic condition and is consistently above the resource levels, but it may also occur in other situations.
OM04 Submit Electronic Attachment	The Submit Electronic Attachment business process begins with receiving attachment information that either a payer requests (solicited) or a provider submits (unsolicited). The solicited attachment information can be in response to requests for more information from the following business processes for example: Process Claim, Process Encounter, Authorize Service, Authorize Treatment Plan, and Manage Estate Recovery.
OM05 Apply Mass Adjustment	The Apply Mass Adjustment business process begins with the receipt or notification of retroactive modifications. These changes may consist of modified rates associated with Healthcare Common Procedure Coding System (HCPCS), Claim Payment/Advice Transaction (CPT), Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the payment transactions such as claims or capitation payment by identifiers (e.g., claim/bill type, HCPCS, CPT, Revenue Code(s), or member identification) that the State Medicaid Agency (SMA) paid incorrectly during a specified date range. The business process applies a predetermined set or sets of parameters that may reverse or amend the paid or denied transactions and repay correctly. *NOTE*: Do not confuse this process with the claim adjustment within the adjudication process. A mass adjustment may involve many previous

MITA Business Process	Definition
	payments based on a specific date or date range affecting single or multiple providers, members, or other payees.
PERFORMANCE MANAGEMENT (PE)	
Compliance Management	
PE01 Identify Utilization Anomalies	The Identify Utilization Anomalies business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable and unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits
PE02 Establish Compliance Incident	The Establish Compliance Incident business process is responsible registration of a case for incident tracking of utilization anomalies. It establishes an incident file, generates incident identification, assigns an incident manager, links to related cases, and collects related documentation.
PE03 Manage Compliance Incident Information	The Manage Compliance Incident Information business process is responsible for the monitoring of incidents of utilization anomalies. Activities include referring (e.g., escalation) incident to another incident manager or agency, modifications to incident information, journaling activities, and disposition of incident.
PE04 Determine Adverse Action Incident	The Determine Adverse Action Incident business process receives an incident from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, corrective action, removal of a provider, contractor, trading partner or member from the Medicaid Program, or the State Medicaid Agency (SMA) may terminate or suspend the case.

MITA Business Process	Definition
PE05 Prepare REOMB	The Prepare REOMB business process is responsible for the creation of Recipient Explanation of Medicaid Benefits (REOMB) for detecting payment problems. The State Medicaid Agency (SMA) sends the REOMB to randomly selected members of Medicaid services. It gives information on the Medicaid services paid on behalf of the member. The communication includes the provider's name, the date(s) of services, and the payment amount(s). Instructions on the communication tell the member what to do if the provider did not actually perform any of the listed services billed directly to him/her by the provider.
PLAN MANAGEMENT(PL)	
Plan Administration	
PL01 Develop Agency Goals and Objectives	The Develop Agency Goals and Objectives business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary. Goals and objectives may warrant change for example, under a new administration, in response to changes in demographics, public opinion or medical industry trends, or in response to regional or national disasters.
PL02 Maintain Program Policy	The Maintain Program Policy Business Process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as federal or state regulations, governing board or commission directives, Quality Improvement Organization's findings, federal or state audits, enterprise decisions, or consumer pressure.
PL03 Maintain State Plan	The Maintain State Plan business process responds to the scheduled and unscheduled prompts to update and revise the Medicaid State Plan. The Medicaid State Plan is the officially recognized statement describing the nature and scope of the State Medicaid program as required under Section 1902 of the Social Security Act.
Health Plan Administration	
PL04 Manage Health Plan Information	The Manage Health Plan Information business process includes evaluation of federal or state regulations, legislative and judicial mandates, federal or state audits governing board or commission directives, Quality Improvement Organization's findings, enterprise decisions, and consumer pressure to develop or enhance enterprise business rules, benefit plans and services available to members. The State Medicaid Agency (SMA) collaboratively develops Health Plan service offerings with input and review by other agencies and stakeholders. This business process ensures the organization is on track

MITA Business Process	Definition
	with the goals and objectives of the SMA and is in concert with statewide goals.
PL05 Manage Performance Measures	The Manage Performance Measures business process involves the design, implementation, and maintenance of mechanisms and measures the State Medicaid Agency (SMA) uses to monitor the business activities and performance of the State Medicaid enterprise's business processes and programs. This includes the steps involved in defining the criteria by which the SMA measures activities and programs (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures). This business process develops the reports and other mechanisms that it uses to track activity and effectiveness at all levels of monitoring. Business Intelligence analysis (i.e., historical, current and predictive views of business operations) occurs within this process.
Health Benefits Administration	
PL06 Manage Health Benefit Information	The Manage Health Benefit Information business process includes the activities for development and implementation of health benefit packages to accommodate service delivery to targeted member populations. The health benefit package accommodates information to support current and future health benefit packages for members eligible for programs administered by the State Medicaid Agency (SMA). The SMA determines benefit terms and limitations, and applicable periods for services defined within a health benefit package.
PL07 Manage Reference Information	The Manage Reference Information business process is responsible for all operations aspects for the creation, modification, and deletions of reference code information. The Process Claim business process additions or adjustments trigger this business process. Additional triggers for Manage Reference Information business process include the addition of a new health plan or benefit, or the modification to an existing program due to the passage of new state or federal legislation, or budgetary modifications. The business process includes revising code information (e.g., Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), National Drug Code (NDC)), and/or revenue codes. Business process also adds rates associated with those codes and updates existing rates. The business process updates and adds information from the Manage Member Information and Manage Provider Information business processes as well as drug formulary, health plan and health benefit information.

MITA Business Process	Definition
PL08 Manage Rate Setting	The Manage Rate Setting business process responds to requests to add or modify rates for any service or product covered by the Medicaid Program.
PROVIDER MANAGEMENT (PM)	
Provider Information Management	
PM01 Manage Provider Information	The Manage Provider Information business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers and their interactions with the State Medicaid Agency (SMA). The Provider data store is the SMA Source of Record (SOR) for provider demographic, business, credentialing, enumeration, performance profiles, payment processing, and tax information. The data store includes contractual terms (e.g., the services the provider is to provide) related performance measures, and the reimbursement rates for those services.
PM08 Terminate Provider	The Terminate Provider business process is responsible for the termination of provider agreement to participate in the Medicaid Program.
Provider Support	
PM02 Manage Provider Communication	The Manage Provider Communication business process receives requests for information, provides publications, and assistance from prospective and current providers' communications (e.g., inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements). The State Medicaid Agency (SMA) may communicate information using a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages. Manage Provider Communication business process handles inquiry from prospective and current providers by providing assistance and responses to individual entities (i.e., bi-directional communication). Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition appeals.

MITA Business Process	Definition
PM07 Manage Provider Grievance and Appeals	The Manage Provider Grievance and Appeal business process handles provider appeals of adverse decisions or communications of a grievance. The State Medicaid Agency (SMA) logs and tracks the grievance or appeal, triages it, and sends it to appropriate reviewers. Staff researches or requests additional information. The SMA may schedule a hearing, conduct actions in accordance with legal requirements, and make a ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the provider's information. SMA formally notifies provider of the decision.
PM03 Perform Provider Outreach	The Perform Provider Outreach business process originates internally within the State Medicaid Agency (SMA) in response to multiple activities (e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, modifications in the Medicaid Program policies and procedures).

10. Appendix B – Acronyms

The following list provides reference to acronyms used within the State Self-Assessment or the MITA Framework.

Acronym	Definition
AA	Application Architecture
ACF	Administration for Children and Families
ACH	Automated Clearing House
ACL	Access Control List
ADA	American Dental Association
ADAP	Alcohol and Drug Awareness Program AIDS Drug Assistance Program
AFDC	Aid to Families with Dependent Children
AHA	American Hospital Association
AIDS	Acquired Immune Deficiency Syndrome
AMA	American Medical Association
ANSI	American National Standards Institute
ANSI ASC X12	American National Standards Institute Accredited Standards Committee X12
APC	Ambulatory Payment Classification
APD	Advance Planning Document
API	Application Programming Interface
AR	Accounts Receivable
ARB	Architecture Review Board
ARRA	American Recovery and Reinvestment Act of 2009
ASC	Accredited Standards Committee

Appendix B – Acronyms

Acronym	Definition
ASN	Abstract Syntax Notation
ASP	Application Service Provider
ASTM	American Society for Testing and Materials
AVR	Automated Voice Response
AVRS	Automated Voice Response System
B2B	Business-to-Business
BA	Business Architecture
BC	Business Capability
BCM	Business Capability Matrix
BENDEX	Beneficiary Data Exchange
BHP	Benefit Health Program Basic Health Program
BP	Business Process
BPDM	Business Process Definition Metamodel
BPEL	Business Process Execution Language
BPM	Business Process Model
BPMN	Business Process Model and Notation
BPSS	Business Process Specification Schema
BPT	Business Process Template
BR	Business Relationship Management
BRM	Business Relationship Management
BS	Business Service
BSDP	Business Service Definition Package
BTOM	Brief Treatment Outcomes Measure

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Acronym	Definition
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAQH	Council for Affordable Quality Healthcare
CCOW	Clinical Context Object Workgroup
CCR	Continuity of Care Record
CDA	Clinical Document Architecture
CDC	Centers for Disease Control and Prevention
CDM	Conceptual Data Model
CDS	Clinical Decision Support
CDT	Current Dental Terminology
CEFACT	Center for the Facilitation of the Administration, Commerce, and Transport
CFR	Code of Federal Regulations
CHI	Consolidated Health Informatics Coordinator for Health Information
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CIM	Common Information Model
CIO	Chief Information Officer
CISO	Chief Information Security Officer
CLIA	Clinical Laboratory Improvement Amendments
CM	Care Management
CMCS	Center for Medicaid and CHIP Services
CME	Common Message Element (superclass or generalized class)
CMIA	Cash Management Improvement Act
CMIS	Content Management Interoperability Services

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Acronym	Definition
CMM	Capability Maturity Model
CMS	Centers for Medicare & Medicaid Services
CO	Contractor Management
COB	Coordination of Benefits
COBOL	Common Business-Oriented Language
COI	Communities of Interest
COO	Concept of Operations
CORE	Committee on Operating Rules for Information Exchange
COTS	Commercial Off-the-Shelf
CPA	Collaboration Protocol Agreement
CPP	Collaboration Protocol Profile
CPT	Current Procedural Terminology Claim Payment/Advice Transaction
CPT-4	Current Procedural Terminology, Fourth Edition
CRM	Customer Relationship Management
CSS	Cascading Style Sheet
DAIS	Data Access and Integration Service
DAML	DARPA Agent Markup Language
DARPA	Directory Access Resolution Protocol Allocation Defense Advanced Research Projects Agency
DBA	Database Administrator
DBMS	Database Management System
DCC	Dental Content Committee
DDI	Design, Development, and Implementation

Appendix B – Acronyms

Acronym	Definition
DEA	Drug Enforcement Administration
DeCC	Dental Content Committee (of the ADA)
DES	Data Encryption Standard
DHS	Department of Homeland Security
DICOM	Digital Imaging and Communications in Medicine
DISA	Data Interchange Standards Association
DLM	Decentralized Label Model
DM	Data Model
DME	Durable Medical Equipment
DMS	Data Management Strategy
DMTF	Distributed Management Task Force
DMV	Department of Motor Vehicles
DMZ	Demilitarized Zone
DOD	Department of Defense
DOJ	Department of Justice
DRG	Diagnosis Related Group
DS	Data Standard
DSMO	Designated Standard Maintenance Organization
DSS	Decision Support System Division of State Systems
DST	Data Standards Table
DUR	Drug Utilization Review
E&E APD	Eligibility & Enrollment Advance Planning Document
E/R	Entity-Relationship

Appendix B – Acronyms

Acronym	Definition
E2E	End-to-End
EA	Enterprise Architecture
EAG	Exchange Architecture Guidance
ebMS	ebXML Message Service
ebXML	Electronic Business Extensible Markup Language
eCTD	Electronic Common Technical Document
EDI	Electronic Data Interchange
EDOC	Enterprise Distributed Object Computing
EE	Eligibility and Enrollment Management
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EHRS	Electronic Health Record System
EIN	Employer Identification Number
EMR	Electronic Medical Record
E-PAL	Enterprise Privacy Authorization Language
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESB	Enterprise Service Bus
eSCM-CL	eSourcing Capability Model for Client Organization
eSCM-SP	eSourcing Capabilities Model for Service Provider
ETL	Extract, Transform, and Load
FDA	Food and Drug Administration
FEA	Federal Enterprise Architecture
FEAF	Federal Enterprise Architecture Framework
FFP	Federal Financial Participation

Appendix B – Acronyms

Acronym	Definition
FFS	Federal Financial System
FHA	Federal Health Architecture
FHIM	Federal Health Information Model
FHIMS	Federal Health Interoperability Modeling and Standards
FICAM	Federal Identity Credential Access Management
FIPS	Federal Information Processing Standard
FISMA	Federal Information Security Management Act
FM	Financial Management Front Matter
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GASB	Governmental Accounting Standards Board
GOTS	Government Off-The-Shelf
GPEA	Government Paperwork Elimination Act
GPRA	Government Performance and Results Act
GSA	General Services Administration
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data and Information Set
HHS	Department of Health & Human Services
HIE	Health Information Exchange
HIFA	Health Insurance Flexibility & Accountability
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Healthcare Integrity and Protection Data Bank

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Acronym	Definition
HIPP	Health Insurance Premium Payment
HIS	Healthcare Information System
HISB	Healthcare Informatics Standards Board
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HIX	Health Insurance Exchange
HL7	Health Level Seven International
HMD	Hierarchical Message Description
HTML	HyperText Markup Language
HTML5	HyperText Markup Language, Version 5
HTTP	Hypertext Transfer Protocol
IA	Information Architecture
IaaS	Infrastructure as a Service
IAPD	Implementation Advance Planning Document
IBM	International Business Machines Corporation
ICD	International Classification of Diseases
ICD-10	International Classification of Diseases 10th Edition
ICF/MR	Intermediate Care Facilities for Persons with Mental Retardation
ICM	Information Capability Matrix
ID	Identification Number
ID-FF	Identify Federation Framework
IDMS	Integrated Data Management System
IEC	International Electrotechnical Commission
IEEE	Institute of Electrical and Electronics Engineers

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Acronym	Definition
IETF	Internet Engineering Task Force
IHS	Indian Health Service
IM	Interaction Model
IMPI	Intelligent Platform Management Interface
INS	Immigration and Naturalization Service
IPSEC	Internet Protocol Security
IRS	Internal Revenue Service
ISO	International Organization for Standardization
IT	Information Technology
ITIL	IT Infrastructure Library
ITU	International Telecommunications Union
IVR	Interactive Voice Response
KPI	Key Performance Indicator
LDM	Logical Data Model
LOB	Line of Business
LOINC	Logical Observation Identifiers Names and Codes
MACBIS	Medicaid and CHIP Business Information and Solutions
MAGI	Modified Adjusted Gross Income
MARS	Management Administration Reporting Subsystem
MCO	Managed Care Organization
MDA	Model-Driven Architecture
ME	Member Management
MET	Message Type
MFCU	Medicaid Fraud Control Unit

Acronym	Definition
MHCCM	Medicaid HIPAA-Compliant Concept Model
MITA	Medicaid Information Technology Architecture
ML	Markup Language
MMA	Medication Modernization Act
MMIS	Medicaid Management Information System
MMM	MITA Maturity Model
MOF	Meta Object Facility
MOU	Memoranda of Understanding
MSIS	Medicaid Statistical Information System
MSMQ	Microsoft Message Queuing Server
MSX	Message Exchange
MTG	MITA Technical Group
NAMD	National Association of Medicaid Directors
NARA	U.S. National Archives and Records Administration
NASA	National Aeronautics and Space Administration
NASCIO	National Association of State Chief Information Officers
NASMD	National Association of State Medicaid Directors
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCCI	National Correct Coding Initiative
NCPD	National Coalition of Pharmaceutical Distributors
NCPDP	National Council for Prescription Drug Programs
NCVHS	National Committee on Vital and Health Statistics
NDC	National Drug Code
NEDSS	National Electronic Disease Surveillance System

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Acronym	Definition
NEMA	National Electrical Manufacturers Association
NET	Nonemergency Transportation
NHII	National Health Information Infrastructure
NHSIA	National Human Services Interoperability Architecture
NIEM	National Information Exchange Model
NIH	National Institutes of Health
NIST	National Institute of Standards and Technology
NMEH	National Medicaid EDI Healthcare
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NSTIC	National Strategy for Trusted Identities in Cyberspace
NTE	Network Termination Equipment
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
NwHIN	Nationwide Health Information Network
OASIS	Organization for the Advancement of Structured Information Standards
OCL	Object Constraint Language
OCR	Optical Character Recognition
ODS	Operational Data Store
OIG	Office of Inspector General
OLAP	Online Analytical Processing
OLTP	Online Transaction Processing

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Acronym	Definition
OM	Operations Management
OM-AM	Objective, Model, Architecture, and Mechanism
OMB	Office of Management and Budget
OMG	Object Management Group
ONC	Office of the National Coordinator for Health Information Technology
OWL	Web Ontology Language
P3P	Platform for Privacy Preference Project
PaaS	Platform as a Service
PBM	Pharmacy Benefits Management
PC	Proxy Certificate
PCAST	President's Council of Advisors on Science and Technology
PCCM	Primary Care Case Management
PCP	Primary Care Physician
PE	Performance Management
PHDSC	Public Health Data Standards Consortium
PHI	Protected Health Information
PHIN	Public Health Information Network
PHR	Personal Health Record
PI	Proxy Issuer
PITAC	President’s Information Technology Advisory Committee
PKC	Public Key Certificate
PKI	Public Key Infrastructure
PL	Plan Management
PM	Provider Management

Appendix B – Acronyms

Acronym	Definition
PMP	Prescription Monitoring Program
PMPM	Per Member Per Month
PMS	Payment Management System
POS	Point of Sale
PPTP	Point-to-Point Tunneling Protocol
PS-TG	Private Sector Technology Group
QMB	Qualified Medicare Beneficiary
QoS	Quality of Service
R&A	Registration and Attestation System
RBAC	Role-Based Access Control
RDBMS	Relational Database Management System
RDF	Reference Description Framework
REOMB	Recipient Explanation of Medical Benefits
REST	Representational State Transfer
RFP	Request for Proposals
RHIN	Regional Health Information Network
RHIO	Regional Health Information Organization
RIM	Reference Information Model
RMP	Remote Management Portlet
RO	Regional Office
ROI	Return On Investment
RPC	Remote Procedure Call
S&P	Security and Privacy
SaaS	Software as a Service

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Acronym	Definition
SAMHSA	Substance Abuse and Mental Health Services Administration
SAML	Security Assertion Markup Language
SCA	Service Component Architecture
SCHIP	State Children's Health Insurance Program
SCIM	Simple Cloud Identity Management
SDLC	System Development Life Cycle
SDO	Standards Development Organization
SDX	State Data Exchange
SEI	Software Engineering Institute
SI	Service Infrastructure
SICAM	State Identity Credential Access Management
SLA	Service Level Agreement
SLM	Service Level Management
SMA	State Medicaid Agency
SMHP	State Medicaid HIT Plan
SMTP	Simple Mail Transfer Protocol
SNMP	Simple Network Management Protocol
SNOMED	Systematized Nomenclature of Medicine
SOA	Service-Oriented Architecture
SOAP	Simple Object Access Protocol
SOR	System of Record
SPP	Security and Privacy Profile
SQL	Structured Query Language
SRM	Standards Reference Model

Acronym	Definition
SSA	Social Security Administration
SS-A	State Self-Assessment
SSD	Service Structure Diagram
SSH	Secure Shell
SSI	Supplemental Security Income
SSN	Social Security Number
SSO	Single Sign-On
SSP	State Supplementary Payment
S-TAG	Systems Technical Advisory Group
SUR	Surveillance and Utilization Review
SURS	Surveillance Utilization Review System
TA	Technical Architecture
TAG	Technical Advisory Group
TAI	Technology Affiliates International
TANF	Temporary Assistance for Needy Families
TC	Technical Capability
TCM	Technical Capability Matrix
TIN	Tax Identification Number
TPA	Trading Partner Agreement
TPL	Third-Party Liability
TPR	Third-Party Recovery
TRM	Technical Reference Model
TS	Technical Service
TSA	Technical Service Area

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Acronym	Definition
TSDP	Technical Service Definition Package
TSM	Technical Service Model
TSRG	Technology Standards Reference Guide
UBL	Universal Business Language
UDDI	Universal Description, Discovery and Integration
UML	Unified Modeling Language
UMLS	Unified Medical Language System
UMM	Unified Modeling Methodology
UN/CEFACT	United Nations Centre for Trade Facilitation and E-Business
UPD	Universal Provider Datasource
URA	Unit Rebate Amount
URI	Uniform Resource Identifier
USHIK	United States Health Information Knowledgebase
USPS	United States Postal Service
VHA	Veterans Health Administration
VHIM	Veterans Health Information Model
VPN	Virtual Private Network
VRS	Voice Response System
W3C	World Wide Web Consortium
WCAG	Web Content Accessibility Guidelines
WEDI	Workgroup for Electronic Data Interchange
WEP	Wired Equivalent Privacy
WFMC	Workflow Management Coalition
WFML	Workflow Management Language

Acronym	Definition
WMX	Web Services for Management Extensions
WOA	Web-Oriented Architecture
WPA	Wi-Fi Protected Access
WS	Web Services
WS-BPEL	Web Services for Business Process Execution Language
WS-CAF	Web Services Composite Application Framework
WSDL	Web Services Description Language
WSDM	Web Services Distribution Management
WSN	Web Services Notification
WSRF	Web Services Resource Framework
WSRM	Web Services Reliable Messaging
WSRP	Web Services Remote Portals
XACML	eXtensible Access Control Markup Language
XAML	eXtensible Application Markup Language
XBRL	eXtensible Business Reporting Language
XDS	Cross-Enterprise Clinical Documents Sharing
XKMS	XML Key Management Specification
XML	eXtensible Markup Language
XrML	eXtensible Rights Markup Language
XSL	eXtensible Style sheet Language
XSLT	Extensible Stylesheet Language Transformation XSL Transformation

11. Appendix C – Terms

The following list provides reference to terms used within the State Self-Assessment or the MITA Framework.

Term	Definition
Access Channels	Access channels are shared physical media such as wireless networks, bus networks, ring networks, hub networks, and half-duplex point-to-point links.
Account	An individual seeking eligibility for enrollment in a qualified health plan through the Exchange, advance premium tax credits, cost-sharing reductions, Medicaid, CHIP, or BHP completes and submits an on-line or paper application for verification and eligibility determination. The Health Insurance Exchange (HIX) or insurance affordability program accepts application data and manages information in an "account" by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes.
Advance Planning Document	The APD is a federally required document for States to inform CMS/ACF/FNS of their intentions related to federally funded programs, and request approval and funding to accomplish their needs and objectives. The term APD refers to a Planning APD, Implementation APD, or to an Advance Planning Document Update.
Affordable Insurance Exchanges	The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. Also referred to as Health Insurance Exchange.
American Recovery and Reinvestment Act of 2009	The ARRA is a federal initiative to improve the quality of care as well as streamline the administration of health services. It provided $25.8 billion for health information technology investments and incentive payments to improve the interoperability and secure data exchange amongst consumers, providers, government, quality entities, and insurers. The ARRA promotes MU of electronic health records and adoption of electronic prescribing of medications to improve patient care. ARRA and HITECH change the

Term	Definition
	structure, use, and sharing of both internal and external health information.
Application (Member)	A single, streamlined form to apply for all applicable state health subsidy programs that is filed online, in person, by mail, or telephone for enrollment or redetermination. An individual may file an application with a Health Insurance Exchange (HIX) (i.e., electronic account) or with an agency.
Application (Provider)	A streamlined form to apply for Medicaid enrollment and revalidating providers and suppliers.
Application Architecture	AA provides the information necessary to develop enterprise applications using both business and technical services. It defines the relationship among the various services and provides an infrastructure orchestrating the processing and workflow during execution.
As-Is	Current business operations.
Beneficiary	The name for a person who has health care insurance through the Medicare or Medicaid program. Referred to as Member in MITA business model.
Business Architecture	The BA describes the needs and goals of individual States and presents a collective vision of the future. The BA focuses on the Medicaid Enterprise.
Business Area	A high level grouping of business processes that share common focus and information. There are ten (10) MITA Business Areas within the MITA Framework 3.0.
Business Capability Matrix	The BCM defines the maturation characteristics for individual business processes. The BCM aligns with the MITA Maturity Model. Applying the maturity model to each business process yields the Business Capability Matrix that shows how business process matures over time.
Business Capability/Level of Maturity	Defines the characteristics of the Medicaid Enterprise at a specific level of maturity. Level 1 is very manual and prone to errors. Level 2 is some of the tasks are automatic, but inconsistencies still exist. Level 3 incorporates automated standardized business rule definitions to streamline responses to requests. Decisions are consistently made with standardized business rule definitions. Level 4 adds access to clinical data, as applicable, which increases the reliability and consistency of its authorization decisions and frees its clinical review staff to focus on exceptions. Level 5 is where a SMA is

Term	Definition
	fully interoperable with other state, local, and federal agencies, providing complete, virtual patient clinical data and national clinical guidelines. Most functions are near-real time.
Business Category	MITA defines a hierarchical division of the MITA Business Model of three (3) tiers: Business Area, Business Category and Business Process. There are 21 MITA business categories within the Framework.
Business Logic	Business logic is a non-technical term generally used to describe the functional algorithms that handle information exchange between a database and user interface.
Business Process	A collection of related, structured activities (a chain of events) that produce a specific service or product for a particular customer or customers. An activity that begins with a unique trigger event and produces a specific result.
Business Process Execution Language	BPEL defines how multiple service interactions coordinate to achieve a business goal, as well as the state and the logic necessary for this coordination. BPEL also introduces systematic mechanisms for dealing with exceptions and processing faults.
Business Process Management	BPM is a disciplined approach to identify, design, execute, document, measure, monitor, and control both automated and non-automated business processes to achieve consistent, targeted results aligned with an organization's strategic goals. BPM involves the deliberate, collaborative, and increasingly technology-aided definition, improvement, innovation, and management of end-to-end business processes that drive business results, create value, and enable an organization to meet its business objectives with more agility.
Business Process Model	A visual diagram or narrative representation of the sequential flow and control logic of a set of related activities or actions.
Business Process Model and Notation	BPMN, previously known as Business Process Modeling Notation, is a standard for business process modeling that provides a graphical notation for specifying business processes in a business process model.
Business Qualities	The Business Capability Matrix defines six business qualities for each business process for each level of maturity. The business qualities include: • Timeliness of business process • Data accuracy and accessibility

Term	Definition
	• Effort to perform business process; the efficiency of business process • Cost effectiveness • Accuracy of business process results • Utility or value to stakeholders
Business Rule	A business rule is a specific, actionable, testable directive that is under the control of the business and supports a business policy. Business rules describe the operations, definitions, and constraints that apply to an organization. Business rules can apply to people, processes, corporate behavior, and computing systems in an organization and are put in place to help the organization achieve its goals.
Business Rules Engine	A business rules engine is a software system that executes one or more standardized business rule definition in a runtime production environment.
Business Service(s)	Business services provide business functionality derived from the BPM at a specific capability level of the BCM. It allows plug-and-play and interoperability. It is implementation-neutral and does not specify platform, binding protocols, programming models, operating systems, underlying infrastructure technologies, or other implementation details to execute the function.
Case Manager	A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.
Center for Consumer Information and Insurance Oversight	The CCIIO is under HHS and CMS. CCIIO is one of the federal reviewers of the funding application process that oversees the implementation of the provisions related to private health insurance.
Center for Medicaid and CHIP Services	CMCS is under HHS and CMS.
Centers for Disease Control and Prevention	The CDC is developing a syndromic-surveillance standard for computer-to-person exchange. The CDC exchanges messages with the Medicaid Enterprise, e.g., those relating to bioterrorism or pandemic notifications.
Centers for Medicare & Medicaid Services	CMS is a branch of HHS. CMS is the federal agency that administers Medicare, Medicaid, and CHIP. CMS provides information for health professionals, regional governments, and consumers.

Term	Definition
Children's Health Insurance Program	CHIP finances coverage for uninsured children. It provides a capped amount of funds to States on a matching basis under title XXI.
Children's Health Insurance Program Reauthorization Act of 2009	The CHIPRA reauthorized the CHIP. The CHIPRA finances CHIP through fiscal year 2013. It is a federal initiative to improve the quality of care and streamline administration of health services.
Clinger-Cohen Act 1996	The Clinger-Cohen Act of 1996 (40 U.S.C. 1401(3)), also known as the Information Technology Management Reform Act is intended to reform acquisition laws and information technology management of the federal government. In Section 5002 of the Act (the "Definitions" section), the Clinger-Cohen Act establishes a definition of information technology that is cited in numerous other federal laws, including Section 508.
Cloud Computing	A model for enabling convenient, on-demand network access to a shared pool of configurable computing resources (e.g., networks, servers, storage, applications, and services) that can be rapidly provisioned and released with minimal management effort or service provider interaction.
Collaboration Protocol Agreement	The CPA or TPA is an agreement between two (2) messaging partners who exchange data.
Collaboration Protocol Profile	The CPP describes and provides the necessary Trading partner details on how they intend to do electronic business. It includes definitions of attributes such as business capabilities and other various protocols related to transport and security.
Commercial Off-the-Shelf	COTS software is a Federal Acquisition Regulation (FAR) term defining a non-developmental item of supply that is both commercial and sold in substantial quantities in the commercial marketplace. COTS procured or utilized, under government contract, in the same precise form, as available to the public.
Committee on Operating Rules for Information Exchange	CAQH launched the CORE that includes more than 130 industry stakeholders – health plans, providers, vendors, CMS and other government agencies, associations, regional entities, standard-setting organizations, and other healthcare entities. CORE participants maintain eligibility and benefits data for more than 150 million commercially insured lives plus Medicare and Medicaid beneficiaries. Working in collaboration they are building consensus on a set of operating rules that will enhance interoperability between providers and payers, streamline eligibility, benefits, and claim data transactions, and

Term	Definition
	reduce the amount of time and resources providers spend on administrative functions (time better spent with patients).
Communities of Interest	COI are collaborative groups of States, agencies, and vendors that share design and implementation information with each other. They provide information and feedback to HHS, CMS, and other agencies as a group. The NMEH is an example of a COI.
Concept of Operations	The COO is a tool to describe current business operations and to define a future transformation that meets the needs of stakeholders and responds to enablers (e.g., new policy, legislation, and technology).
Conceptual Data Model	The CDM is a blueprint or conceptual plan for building information systems. It is a tool to communicate business processes and enterprise strategies.
Content Management Interoperability Services	CMIS are domain model and Web service standards for working with enterprise content management repositories and systems.
Coordination of Benefits	COB is information collection across multiple agencies to coordinate the payment of healthcare benefits.
Corrective Action Plan	A CAP is required from the State Medicaid Agency or provider when it does not meet CMS or SMA requirements.
Council for Affordable Quality Healthcare	The CAQH develops and implements administrative solutions that produce meaningful, concrete benefits for physicians, allied health professionals, their staffs, patients, and plans. They are the authors and collaborators of CORE and UPD.
Data Management Strategy	The DMS provides the approach to integrating and organization data through reference to data governance, data standards, data processes and procedures, data integration, and metadata repository. The DMS coordinates the goal of getting the right data to the right people at the right time.
Data Model	A model that depicts the logical structure of data.
Data type	Data types are descriptors of a set of values that lack identity (independent existence and the possibility of side effects). Data types include primitive predefined types and user-definable types. Primitive types include numbers, strings, and Boolean values. User-definable types are enumerations. Anonymous data types intended for implementation in a programming language may be defined using language types

Term	Definition
	within profiles. All three (3) data types and their literals make up the vocabulary.
Drug Enforcement Administration	DEA, a component of the U.S. Department of Justice responsible for enforcing laws and regulations governing narcotics and controlled substances.
E-Government Act 2002	The Electronic Government Act of 2002 was signed into law on December 17, 2002. Electronic Government is defined as the Government use of web-based Internet applications or other information technology to enhance the access to and delivery of government information and services to the public, other agencies, and other Government entities. The E-Government Act of 2002 establishes a new agency the Office of Electronic Government within the Office of Management and Budget. The act creates a Chief Information Council that works with other federal agencies and state and local governments to help develop electronic technology policies, requirements, and strategies. An E-Government Fund provides funding for projects intended to allow for easier public access to information, improved government services and transactions, and enhanced agency information technology project coordination and planning.
Electronic Data Interchange	EDI is a service gateway.
Electronic Health Record	EHR is an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.
Electronic Medical Record	An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.
Enterprise Architecture	The meta-architecture of an organization, or the sum of all architectures within an organization.
Enterprise Data Modeling	A graphical model that describes the high-level data relationships between stakeholders within an enterprise.
Enterprise Modeling	Enterprise modeling is the abstract representation, description, and definition of the structure, processes, information, and resources of an identifiable business, government body, or other large organization.

Term	Definition
	The process of building models of whole or part of an enterprise (e.g. process models, data models, resource models, new ontologies, etc.). An enterprise model is a representation of the structure, activities, processes, information, resources, people, behavior, goals, and constraints of a business, government, or other enterprises. A method of modeling the pertinent aspects of an organization's structure.
Enterprise Service Bus	An ESB is a software architecture model used for designing and implementing the interaction and communication between mutually interacting software applications in Service Oriented Architecture. As a software architecture model for distributed computing it is a specialty variant of the more general client server software architecture model and promotes strictly asynchronous message oriented design for communication and interaction between applications. Its primary use is in Enterprise Application Integration of heterogeneous and complex landscapes.
Enterprise SOA	An enterprise service-oriented architecture is a style of design that guides all aspects of creating and using business services throughout their lifecycle.
eXtensible Business Reporting Language Reporting	XBRL is a freely available, market-driven, open, and global standard for exchanging business information. XBRL allows information modeling and the expression of semantic meaning commonly required in business reporting.
Federal Financial Participation	FFP describes the process of providing States with federal funds to pay for their mechanized claims processing and information retrieval systems as well as the Medicaid eligibility determination and enrollment activities as set forth in the Affordable Care Act of 2010. FFP is also distributed to States to pay for a percentage of every transaction (claim) that is processed.
Federal Health Information Model	The FHIM is a project under the FHIMS that is an initiative of the Federal Health Architecture. Its intention is to develop a common logical information model for the healthcare line of business.
Federal Hub Services	The federally operated data hub that verifies citizenship, immigration status, and tax information with the SSA, DHS, and the IRS.
Federal Identity, Credential, and Access	The FICAM is a resource for agency implementers of identity, credential, and access management programs. The FICAM

Term	Definition
Management Roadmap and Implementation Guidance	Roadmap outlines a common framework for ICAM within the federal government and provides supporting implementation guidance for program managers, leadership, and stakeholders as they plan and execute a segment architecture for ICAM management programs.
Federal Information Processing Standard	FIPS is a publicly announced standardization developed by the United States federal government for use in computer systems, by all non-military government agencies and by government contractors, when properly invoked and tailored on a contract. Many FIPS pronouncements are modified versions of standards used in the technical communities.
Federal Information Security Management Act of 2002	The FISMA recognizes the importance of information security to the economic and national security interests of the United States. The act requires each federal agency to develop, document, and implement an agency-wide program to provide information security for the information and information systems that support the operations and assets of the agency, including those provided or managed by another agency, contractor, or other source.
Federal Medical Assistance Percentages	FMAP are the percentage rates used to determine the matching funds rate allocated annually to medical and social service programs such as Medicaid and CHIP.
Federated Security	Federated security allows a clean separation between the service a client is accessing and the associated authentication and authorization procedures. Federated security also enables collaboration across multiple systems, networks, and organizations in different trust realms.
General Accounting Office	The U.S. Government Accountability Office (GAO) is an independent, nonpartisan agency working for the Congress that investigates how the federal government spends taxpayer dollars.
Generally Accepted Accounting Principles	GAAP refer to the standard framework of guidelines for financial accounting used in any given jurisdiction; generally known as accounting standards.
Government Accounting Standards Board	GASB is a private, non-governmental organization that is the source of GAAP, which governments in the United States use.
Guidance for Exchange and Medicaid Information Technology Systems	CMS provides Guidance for Exchange and Medicaid Information Technology Systems (IT Guidance) to assist States to achieve interoperability between IT components in the federal and state entities that provide health insurance

Term	Definition
	coverage through the Health Insurance Exchange, Medicaid, or CHIP.
Health & Human Services	HHS is the U.S. government's principal agency assigned to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves.
Health Benefit	Services covered by the health plan to include at least the following general categories and the items and services covered within the categories: A) Ambulatory patient services, B) Emergency Services, C) Hospitalization, D) Maternity and newborn care, E) Mental health and substance use disorder service, including behavioral health treatment, F) Prescription drugs, G) Rehabilitative and habilitative services and devices, H) Laboratory services, I) Preventative and wellness services and chronic disease management and J) Pediatric Services.
Health Information Exchange (HIE)	The electronic movement of health-related information among organizations according to nationally recognized standards.
Health Information Technology for Economic and Clinical Health (HITECH)	The HITECH Act, is part of the American Recovery and Reinvestment Act (ARRA) of 2009, and signed into law on February 17, 2009, to promote the adoption and MU of health information technology.
Health Insurance Coverage	Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.
Health Insurance Exchange (HIX)	The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. Also referred to as Affordable Insurance Exchanges.
Health Insurance Portability and Accountability Act of 1996	HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. The AS provisions require the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers to improve the efficiency and effectiveness of the nation's health care system through the use of electronic data interchange. It also addresses security and privacy of healthcare data.

Term	Definition
Health Insurance Premium Payment	The HIPP is a Medicaid program allowing a member to receive free private health insurance that its state's Medicaid program pays for entirely.
Health Plan	A health care benefit package for the coverage of medical services and payment for those services. A state may have multiple benefit packages based on their Medicaid State Plan and delivery of services. An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.
HyperText Markup Language version 5	HTML5 is a language for structuring and presenting content for the World Wide Web, and is a core technology of the Internet originally proposed by Opera Software.
ICD-10/5010	ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2013. Standards for electronic health care transactions, such as claims, eligibility inquiries, and remittance advices, change from Version 4010/4010A1 to Version 5010 on January 1, 2012. Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10 codes, and must be in place first before the changeover to ICD-10. If providers do not conduct electronic health transactions using Version 5010 as of January 1, 2012, delays in claim reimbursement may result.
Information Architecture	IA describes a logical architecture for the Medicaid Enterprise. It provides a description of the information strategy, architecture, and data to a sufficient level that it may be used to define the data needs that will enable the future business processes of their Medicaid Enterprise.
Information Capability Matrix	The ICM defines the information capabilities, (i.e., DMS, CDM, LDM and Data Standards) identified in the business process to enable technical capabilities. The ICM aligns with the MITA Maturity Model. Applying the maturity model to each information capability yields the ICM, which shows how a business area matures over time.
Institute of Electrical and Electronics Engineers	The IEEE (read I-Triple-E) is a non-profit professional association headquartered in New York City that is dedicated to advancing technological innovation and excellence.
Insurance Affordability Programs	Include Medicaid, CHIP, advance payments of premium tax credits and cost-sharing reductions through the Exchange, and any state-established Basic Health Program, if applicable.

Term	Definition
Interactive voice response	IVR is a technology that allows a computer to interact with humans through the use of voice and dual-tone multi-frequency signaling keypad inputs.
Kiosk	An electronic kiosk (or computer kiosk or interactive kiosk) houses a computer terminal that often employs custom kiosk software designed to function flawlessly while preventing users from accessing system functions.
Logical Data Model	The LDM provides guidance and specifics to IT staff on how to design MITA Enterprise service interfaces. It shows a data subject area divided into data classes, and includes the relationships among those classes, with attributes defined as needed for one drilled-down business process, i.e., all of the data elements in motion in the system or shared within the Medicaid Enterprise. The MITA LDM does not include state-specific data objects and relationships.
Master Data Management	Master Data Management comprises a set of processes and tools that consistently defines and manages the master data (i.e. non-transactional data entities) of an organization, which may include reference data.
Medicaid and CHIP Business Information and Solutions Council	The MACBIS is an internal CMS council to provide leadership and guidance for a more robust and comprehensive information management strategy for Medicaid, the CHIP, and state health programs. The council's strategy includes: (1) promoting consistent leadership on key challenges facing state health programs, (2) improving the efficiency and effectiveness of federal/state partnership, (3) making data on Medicaid, CHIP, and state health programs more available to stakeholders, and (4) reducing duplicative efforts within CMS and minimizing the burden on States.
Medicaid Enterprise	The Medicaid Enterprise is defined in the MITA context as the domain in which federal matching funds apply. The domain uses interfaces and bridges among Medicaid stakeholders, including providers, beneficiaries, insurance affordability programs (e.g., CHIP, tax credits, Basic Health Program), Health Insurance Exchange (HIX), Health Information Exchange (HIE), other state and local agencies, other payers, CMS, and other federal agencies. The sphere of influence touched by MITA (e.g., national and federal initiatives such as HITECH). The Medicaid Enterprise includes all of the individual State Medicaid Enterprises.

Term	Definition
Medicaid Information Technology Architecture	MITA is an initiative of CMS intended to foster integrated business and IT transformation across the Medicaid Enterprise to improve the administration of the Medicaid Program. MITA is a national framework intended to support improved systems development and health care management for the United States Medicaid Enterprise.
Medicaid Management Information System	A CMS approved system that supports the operation of the Medicaid Program. The MMIS includes the following types of sub-systems or files: beneficiary eligibility, Medicaid provider, claims processing, pricing, SURS, MARS, and potentially encounter processing.
Medicaid State Plan	The officially recognized statement describing the nature and scope of the State Medicaid program as required under Section 1902 of the Social Security Act. A state submits modifications to CMS as a Medicaid State Plan Amendment (SPA).
Medicaid Statistical Information System	The Medicaid Statistical Information System collects, manages, analyzes, and disseminates information on pharmacy, beneficiaries, utilization, and payment for services covered by State Medicaid programs. CMS analyses it to produce Medicaid program characteristics and utilization information for States, and to provide it with a large-scale database of state pharmacy and services for other analyses. States provide CMS with federal fiscal year quarterly electronic files containing specified data elements for: (1) persons covered by Medicaid (Eligible files); and, (2) adjudicated claims (Paid Claims files) for medical services reimbursed with Title XIX funds.
Medicare	Medicare is health insurance for the following: (1) people 65 or older; (2) people under 65 with certain disabilities; and people of any age with End-Stage Renal Disease (ESRD).
Member	The name for a person who has health care insurance through the Medicare or Medicaid program. Also referred to as Beneficiary.
MITA business and technical services	Provide a standard set of operations with a standard interface for all business processes.
MITA Business Process Model	The MITA BPM describes what an organization or business does, including the events that initiate those processes (i.e., the trigger event). A BPM also describes the results of those processes. The BPM is a key building block within the MITA framework. It presents a hierarchy of Medicaid business

Term	Definition
	processes organized into categories (or tiers) of processes (i.e., Tier 1 is the business area, Tier 2 is the business category, and Tier 3 is the business process). Each business process has a defined trigger and business outcome. This hierarchy helps to categorize business activities and ensure relevant functions in the Framework. The MITA BPM consists of ten (10) Business Areas, twenty-one (21) business categories and eighty (80) business processes.
MITA Business Process Template	The MITA BPT is a template used to capture the description of each business process in the Business Process Model. The business processes cover current and near-term operations. The BPT captures the description, trigger events, results, business process steps, shared data, predecessors, successors, constraints, failures, and performance standards.
MITA Framework	Consolidation of principles, business and technical models, and guidelines that creates a template for States to use to develop their individual State Medicaid Enterprise. Designed to evolve over time. It contains three (3) parts: Business Architecture, Information Architecture, and Technical Architecture.
MITA Maturity Model	The MMM establishes boundaries and measures used to determine whether a business capability is correctly and sufficiently defined.
National Archives and Records Administration	The NARA is an independent agency of the United States government charged with preserving and documenting government and historical records and with increasing public access to those documents, which comprise the National Archives.
National Association of Chief Information Officers	NASCIO represents the state chief information officers and information technology executives and managers from the States, territories, and the District of Columbia. It provides the exchange of information to promote the adoption of IT best practices and innovations.
National Association of Medicaid Directors	NAMD is responsible for ensuring that the Medicaid program provides high quality, cost effective care to its state Medicaid beneficiaries through best practices and technical assistance.
National Human Services Interoperability Architecture	NHSIA is a framework to support: common eligibility and information sharing across programs, agencies, and departments; improved efficiency and effectiveness in delivery of human services; prevention of fraud; and better outcomes for children and families. It will consist of business, information,

Term	Definition
	security, and technology models to guide programs and States in the accurate reporting and delivery of services.
National Information Exchange Model	NIEM is responsible for the development, dissemination, and support of enterprise-wide information exchange standards and processes that enable automated information sharing.
National Institute of Standards and Technology	NIST, known between 1901 and 1988 as the National Bureau of Standards (NBS), is a measurement standards laboratory, otherwise known as a National Metrological Institute (NMI), which is a non-regulatory agency of the United States Department of Commerce. The institute's official mission is to Promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology in ways that enhance economic security and improve our quality of life.
Nationwide Health Information Network	NwHIN consists of interoperable RHIO consenting to standardized data content and communication protocols that allows information exchange across the country for authenticated subscribers.
No Wrong Door	An initiative to ensure that families receive appropriate services regardless of the portal they use to enter the system. The initiative integrates services from different state agencies and policy areas. When a person presents for services at any point in the health care or social services system, he or she is guided toward all appropriate services.
Office of Inspector General	The OIG conducts independent investigations, audits, inspections, and special review of the U.S. DOJ personnel and programs to detect waste, fraud, abuse, and misconduct, and to promote integrity, efficiency, and effectiveness in DOJ operations.
Office of Management and Budget's, Federal Enterprise Architecture, Reference Models	The OMB FEA RM. The FEA consists of a set of interrelated reference models designed to facilitate cross-agency analysis and the identification of duplicative investments, gaps and opportunities for collaboration within and across agencies. Collectively, the reference models comprise a framework for describing important elements of the FEA in a common and consistent way. Through the use of this common framework and vocabulary, IT portfolios can be better managed and leveraged across the federal government.
OWL-S	OWL-S is an ontology, within the OWL-based framework of the Semantic Web, for describing Semantic Web Services. It

Term	Definition
	enables users and software agents to automatically discover, invoke, compose, and monitor Web resources offering services, under specified constraints.
Patient	A recipient of health care services within the health care system. A national health identification is provided to the individual. National Health ID is sometimes referred to as the National Individual Identifier.
Performance Measure	Is based on established Performance Standards and tracks past, present, and future business activity.
Performance Metric	Is a measure of an organization's activities and performance also known as key performance indicators. Often closely tied in with outputs, performance metrics should usually encourage improvement, effectiveness, and appropriate levels of control.
Performance Standard	A management-approved expression of the performance threshold(s), requirement(s), or expectation(s) that must be met to be appraised at a particular level of performance.
Personal Health Information	PHI refers to the demographic information, medical history, tests and laboratory results, and other data a provider collects to identify an individual and to determine appropriate health care.
Personal Health Record	PHR is an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.
Point of sale	POS or checkout is the location where a transaction occurs. A "checkout" refers to a POS terminal or more generally to the hardware and software used for checkouts, the equivalent of an electronic cash register.
Population	Is a targeted group of individuals who meet specific criteria (e.g., member, provider, cultural, or diagnosis). SMA identifies target groups by analyzing data stores, performance measures, and other indicators.
President's Council of Advisors on Science and Technology	PCAST is a council, chartered (or re-chartered) in each administration with a broad mandate to advise the President on science and technology.

Term	Definition
RA Section 508 1986	In 1998 the US Congress amended the Rehabilitation Act of 1973 to require federal agencies to make their electronic and information technology accessible to people with disabilities. Section 508 is enacted to eliminate barriers in information technology, to make available new opportunities for people with disabilities, and to encourage development of technologies that will help achieve these goals. The law applies to all federal agencies when they develop, procure, maintain, or use electronic and information technology. Under Section 508 (29 U.S.C. § 794d), agencies must give disabled employees and members of the public access to information that is comparable to the access available to others.
Regional Health Information Organization	RHIO brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving healthcare in that community.
Registration and Attestation System	R&S tracks whether providers have successfully demonstrated MU to quality for the EHR incentive payment program.
Representation State Transfer (REST) Architecture - Web Services	A RESTful web service (also called a RESTful web API) is a simple web service implemented using HTTP and the principles of REST. The REST Web is the subset of the WWW (based on HTTP) that agents provide uniform interface semantics (essentially create, retrieve, update and delete) rather than arbitrary or application-specific interfaces, and manipulate resources only by the exchange of representations. Furthermore, the REST interactions are stateless in the sense that the meaning of a message does not depend on the state of the conversation.
Request for Proposal	The RFP identifies business, information, and technical requirements and standards to include as evaluation criteria for a new Medicaid Enterprise.
Resource Description Framework	The RDF is a family of W3C specifications originally designed as a metadata data model. It is used as a general method for conceptual description or modeling of information that is implemented in web resources, using a variety of syntax formats.
Semantic Web	The Semantic Web is a collaborative movement led by the World Wide Web Consortium (W3C) that promotes common formats for data on the World Wide Web. By encouraging the inclusion of semantic content in web pages, the Semantic Web

Term	Definition
	aims at converting the current web of unstructured documents into a "web of data". It builds on the W3C's RDF.
Service Engines	Service Engines are tools that support Web services specifications such as XML, SOAP, WSDL, and the full Web services stack, with support for essential WS specifications such as WS-Addressing, WS-Security and WS-ReliableMessaging.
Service Infrastructure	The service infrastructure is the system necessary to deliver the application-oriented functions across the network. In the abstract, it is composed of the service agent, the service protocol, and the service server.
Service Portal	Service Portal is a term, generally synonymous with gateway, for a World Wide Web site that is a major starting site for users when they get connected to the Web or that users tend to visit as an anchor site.
Service-Oriented Architecture	SOA is a software design strategy that packages common functionality and capabilities (services) with standard, well-defined service interfaces, to produce formally described functionality invoked using a published service contract. Service users need not be aware of “what’s under the hood.” A service built using new applications, legacy applications, COTS software, or all three. Services designed so that they change to support state-specific implementations.
Seven Standards and Conditions	CMS Enhanced Funding Requirements: Seven Conditions and Standards (a.k.a. Seven Standards and Conditions) describe the requirements that States must adhere to receive enhanced federal matching funds for Medicaid Information Technology (IT). The Seven Standards and Conditions are Modularity Standard, MITA Condition, Industry Standards Condition, Leverage Condition, Business Results Condition, Reporting Condition, and Interoperability Condition.
Seven Standards and Conditions Capability Matrix	The Seven Standards and Conditions Capability Matrix define the maturation characteristics for each of the Seven Standards and Conditions. It aligns with the MMM. Applying the maturity model to each standard and conditions for each of the three (3) architectures (i.e., business, information, technology) yields the Seven Standards and Conditions Capability Matrix, which shows how the Medicaid Enterprise matures over time.
Seven Standards and Conditions Maturity Model	The Seven Standards and Conditions Maturity Model establishes the boundaries and measures used to determine

Term	Definition
	whether a standard or condition capability is correctly and sufficiently defined.
Shared Eligibility Services	Shared eligibility services support the no wrong door initiative for eligibility and enrollment functions offered by the Health Insurance Exchange (HIX). They reduce administrative costs and improve service delivery.
Shared Utility Services Registry	A registry of shared web services that support applications utilizing web services.
Smart Common Input Method platform	The SCIM is an input method platform containing support for more than thirty languages for POSIX-style operating systems.
State Identity Credential Access Management	SICAM provides a roadmap that outlines a strategic vision for identity, credential, and access management efforts across state governments.
State Medicaid Agency	The SMA is responsible for the operation of a Medicaid program within a state.
State Medicaid Enterprise	The state domain that centers on the Medicaid environment including leveraged systems and interconnections among Medicaid stakeholders, providers, beneficiaries, insurance affordability programs (e.g., CHIP, tax credits, Basic Health Program), Health Insurance Exchange (HIX), Health Information Exchange (HIE), other state and local agencies, other payers, CMS, and other federal agencies.
State Self-Assessment	The MITA SS-A is a structured method for documenting and analyzing the As-Is operations and To-Be environment of Business, Information, and Technical capabilities of the State Medicaid Enterprise. The SS-A facilitates alignment of the State Medicaid Enterprise to MITA Business, Information, and Technical Architectures, as well as the Seven Standards and Conditions. It provides the foundation for a gap analysis that supports the state's transition planning. The SS-A helps focus preparation of the APD to reflect an achievable funding request.
Syntactic and Semantic Match	When both the structure and meaning of the data are consistent.
Technical Architecture	The TA Framework describes the technical and application design aspects of the Medicaid Enterprise by leveraging industry standards and best practices. It defines a set of technical services and standards to plan and specify future systems. These standards include: adoption and use of

Term	Definition
	common industry standards, identification of common vs. state specific processes, data and technical solutions, business driven design processes, built in security and delivery, scalability, interoperability and extendibility components, and performance standards.
Technical Capability Matrix	The TCM defines each technical capability with five (5) levels of maturity due to changes in business requirements or technology. The TCM technical components associated with each level are enablers of the corresponding business capability. Each technical capability consists of one or more technical services. The TCM aligns with the MMM. Applying the maturity model to each technical capability yields the TCM, which shows how a business area matures over time.
Technical Management Strategy	TMS describes the processes, techniques, and technologies the State Medicaid Enterprise uses to achieve optimal sharing of services and information.
Technical Service Area	TSA is a sub-grouping for TA modeling that assist the evaluation of the TA maturity level during the SS-A. The category is similar to the division of a Business Area for Business Architecture. The three (3) sub-groupings include Access and Delivery, Intermediary and Interface, and Interface and Utility.
Technical Service Classifications	Technical Service Classifications define a standard and/or functionality for a technical process aligning common factors of a state's implementation. Allows plug-and-play and interoperability.
Technical Service Parts	The Technical Service Parts define the Service Name, Purpose, Business Logic, Constraints, Formal Interface Definition, Use Case, Solution Set, Structure and Activity Diagram, Performance Standards, Test Scenarios and Cases, and mapping to MITA data models.
Technical Services	Technical Services provide underlying independent technical functionality (e.g., forms management, security, etc.) in alignment with a maturity level of the TCM. They are implementation-neutral, component-driven technical outlines leveraging standardized vocabulary to allow agencies to leverage sharing and collaboration.
To-Be	Future business environment.
Trade Partner Agreement	A TPA is a formalized relationship with an external entity with whom business is conducted (i.e., business partner).

Term	Definition
Transformation	The modernization of information systems to meet business needs. With systems transformation, States can meet coverage goals, minimize duplication, ensure effective reuse of infrastructure and applications, produce seamlessness for consumers, and ensure accuracy of program placements.
Unified Modeling Language	The Object Management Group (OMG) Unified Modeling Language and Unified Modeling Methodology is a standard way to write a system's blueprints, including business processes, and system functions as well as programming language statements, database schemas, and reusable software components. States use the standard for modeling systems from conceptual through design and implementation.
Use Case	A system analysis methodology to identify, clarify, and organize system requirements. A use case most often is a narrative description and may include a use case diagram showing the actors and activity of a business process.
Use Case Diagram	A context diagram showing the actors (e.g. roles, systems, processes) and the high-level activity for a business process. A use case diagram is usually depicted using UML or BPMN.
Web Service Definition Language	WSDL defines services as collections of network endpoints, or ports. This allows the reuse of messages (abstract descriptions of the data exchange). States use WSDL for defining the interface specifications for all MITA business and technical services.
Web-Oriented Architecture	WOA is a style of software architecture that extends SOA to web based applications, and is considered a lightweight version of SOA.
Wi-Fi Protected Access	WPA is a security protocol and security certification program the Wi-Fi Alliance develops to secure wireless computer networks. The Alliance defined these in response to serious weaknesses researchers had found in the previous system, WEP.
Wired Equivalent Privacy	WEP is a weak security algorithm for IEEE 802.11 wireless networks. Introduced as part of the original 802.11 standard ratified in September 1999, its intention is to provide data confidentiality comparable to that of a traditional wired network. WEP, recognizable by the key of 10 or 26 hexadecimal digits, is widely in use and is often the first security choice presented to users by router configuration tools.

Appendix C – Terms

Term	Definition
World Wide Web Consortium	The W3C is the main international standards organization for the World Wide Web.
XML Schema Definition	XML Schema is a document written in XML Schema language that defines the syntax rules and data types for a message or a document.

12. Appendix D – MITA Scorecards

MITA Scorecards for the Business Architecture (BA), Information Architecture (IA), Technical Architecture (TA), and Seven Standards and Conditions (SSC) are maintained in the MITA 3.0 SS-A project repository.

13. Appendix E – MITA State Self-Assessment Details

Nebraska MITA 3.0 Business Process templates are maintained in the MITA 3.0 SS-A project repository.

14. Appendix F – Business Architecture Profile

The Business Architecture (BA) Profile illustrates the business capabilities for each business area in the MITA Framework 3.0. The table articulates the As-Is maturity levels for each business area in the format specified by the MITA Framework 3.0, SS-A Companion Guide.

Business Architecture 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			
Business Architecture 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 Information	As-Is	To-Be			
CM03 Manage Population Health Outreach	As-Is		To-Be		
CM04 Manage Registry	As-Is	To-Be			
CM05 Perform Screening and Assessment	As-Is		To-Be		
CM06 Manage Treatment Plan and Outcomes	As-Is	To-Be			
CM07 Authorize Referral		As-Is	To-Be		
CM08 Authorize Service	As-Is		To-Be		
CM09 Authorize Treatment Plan	As-Is	To-Be			
Business Architecture 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 and Appeal	As-Is	To-Be			
Business Architecture Profile – Eligibility And 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			
Business Architecture 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 Information		As-Is To-Be			
FM07 Manage Accounts Receivable Funds		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		
		As-Is			

FM13 Manage Accounts Payable Information		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			
Business Architecture 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 and Member Communication		As-Is	To-Be		
ME03 Perform Population and Member Outreach	As-Is	To-Be			
ME08 Manage Member Grievance and Appeal	As-Is	To-Be			
Business Architecture 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 Claims	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 Encounters	As-Is		To-Be		
Business Architecture 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			
Business Architecture Profile – Plan Management					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PL01 Develop Agency Goals and 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			
Business Architecture 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 and Appeal	As-Is	To-Be			
PM08 Terminate Provider		As-Is To-Be			

15. Appendix G – Information Architecture Profile

The Information Architecture (IA) Profile illustrates the information capabilities for each business area in the MITA Framework 3.0. The table articulates the As-Is maturity levels for each business area in the format specified by the MITA Framework 3.0, SS-A Companion Guide.

Information 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			

16. Appendix H – Technical Architecture Profile

The Technical Architecture (TA) Profile illustrates the information capabilities for each business area in the MITA Framework 3.0. The table articulates the As-Is maturity levels for each business area in the format specified by the MITA Framework 3.0, SS-A Companion Guide.

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			

17. Appendix I – Seven Conditions and Standards Profile

The table below displays the As-Is and To-Be environment for MLTC based on the Seven Standards and Conditions for the Business Processes in the MITA Framework 3.0. For TA, scoring was done at the Technical Service Area level and scores then applied equally to each Business Area.

Seven Standards and Conditions 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 2	Level 3
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 2	Level 2
Business Area: Care Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 2	Level 2
Business Area: Contractor Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 1	Level 2

Interoperability Condition	Level 2	Level 2
Business Area: Eligibility & Enrollment Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 2	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 2	Level 2
Business Area: Financial Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 2	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 2	Level 2
Interoperability Condition	Level 2	Level 2
Business Area: Member Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 2	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 2	Level 2
Interoperability Condition	Level 2	Level 2
Business Area: Operations Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 1	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 2	Level 2
Interoperability Condition	Level 2	Level 2
Business Area: Performance Management		
Modularity Standard	Level 2	Level 2

MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 2	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 2	Level 2
Interoperability Condition	Level 2	Level 2
Business Area: Plan Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 2	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 2	Level 2
Business Area: Provider Management		
Modularity Standard	Level 1	Level 2
MITA Condition	Level 2	Level 3
Industry Standards Condition	Level 2	Level 2
Leverage Condition	Level 1	Level 2
Business Results Condition	Level 1	Level 1
Reporting Condition	Level 1	Level 2
Interoperability Condition	Level 2	Level 2